Occupational Therapist and Client Experiences of a Mental Health Group

Shirley E. Jones, B.H.Sc.(OT)

Department of Graduate and Undergraduate Studies in Education

Submitted in partial fulfillment
of the requirements for the degree of
Master of Education
Faculty of Education, Brock University
St. Catharines, Ontario

November 25, 1994

Abstract

The purpose of this qualitative study was to understand the client and occupational therapist experiences of a mental health group. A secondary aim was to explore the extent to which this group seemed to have reflected a client-centred approach. The topic emerged from personal and professional issues related to the therapist as teacher and to inconsistencies in practice with the profession's client-centred philosophy. This philosophy, the study's frame of reference, was established in terms of themes related to the client-therapist relationship and to client values. Typical practice was illustrated through an extensive literature review. Structured didactic-experiential methods aiming toward skill development were predominant.

The interpretive sciences and, to a lesser extent, the critical sciences directed the methodology. An ongoing support group at a community mental health clinic was selected as the focus of the study; the occupational therapist leader and three members became the key participants. A series of conversational interviews, the core method of data collection, was supplemented by observation, document review, further interviews, and fieldnotes. Transcriptions of conversations were returned to participants for verification and for further reflection.

Analysis primarily consisted of coding and organizing data according to emerging themes. The participants' experiences of group, presented as narrative stories within a group session vignette, were also returned to participants. There was a common understanding of the group's structure and the importance of having "air time" within the group; however, differences in perceptions of such things as the importance of the group in members' lives were noted. All members valued the therapeutic aspects of group, the role of group as weekly activity and, to a lesser extent, the learning that came from group. The researcher's perspective provided a critique of the group experience from a client-centred perspective. Some areas of consistency with client-centred practice were noted (e.g., therapist attitudes); however the group seemed to function far from a client-centred ideal. Members held little authority in a relationship dominated by the leaders, and leader agendas rather than member values controlled the session. Possible reasons for this discrepancy ranging from past health care encounters through to co-leader discord emerged.

The actual and potential significance of this study was discussed according to many areas of implications: to OT practice, especially client-centred group practice, to theory development, to further areas of research and methodology considerations, to people involved in the group and to my personal growth and development.

Acknowledgements

This thesis has been part of a personal journey; but not a solitary journey. Many have accompanied me and enabled me. I would like to express my gratitude here to those most vital to this work:

First to Patricia Cranton, my advisor and despite our geographical distance, my closest companion on this academic part of my journey. I have appreciated all that you have done and not done as you have so artfully and so sensitively guided me. Through our relationship I have come to experience the essence and the potential of education.

To the late Jane McCreary, my professional mentor. As Jane lived the last months of her life, she encouraged me to create and seize opportunities so that I may realize what is important in my own life. She encouraged me to pursue this graduate degree.

To each of the four people who participated with me in this study. You unselfishly allowed me to enter your lives and, in learning about your experiences, I was able to learn from you.

To all the faculty I have encountered in the Master of Education Program at Brock University, especially committee members Susan Drake and John Novak. Without fail, I have encountered positive support and models of enthusiasm toward inquiry. I have appreciated and benefitted from your sharing.

And finally, to my family - Gaston, Adrian, and Rachelle - who will continue with me on this journey. You have been and will always be my sustaining inspiration. Throughout this work, you surrounded me with patience, support, and love, and enabled me to fulfill this part of my dream.

Thank you.

Table of Contents

Page

CHAPTER ONE: INTRODUCTION

Purpose of the Study

The purpose of this study was to advance the understanding of the occupational therapy practice of educationally-oriented groups with mental health clients. A single group will be described primarily from two perspectives: the clients' and the therapist's experience. Interpretation will then continue toward the study's secondary aim to explore the extent to which this group reflected a client-centred approach.

Background to the Problem and Rationale for Study

Occupational Therapy

Occupational therapy (OT) is a health profession which is essentially concerned with maximizing people's abilities and satisfaction in carrying out their life activities. At the turn of the century, a recognized discipline that treated people through occupying them in activities existed. Subsequent to the first use of the label "occupational therapy" in 1914, the name was consistently adopted. Shortly after, a professional association was formed in the United States and objectives and principles were established

(Gilfoyle, 1984).

In Canada, a client-centred approach has recently been embraced as a philosophical foundation of professional practice and a generic practice model known as the model of occupational performance has been developed (CAOT, 1991). The concept of "client-centred" will be more fully described in chapter two as this study's frame of reference. Occupational therapy aims, within a client-centred practice, to prevent dysfunction, promote, maintain or restore function, also known as occupational performance. According to the model, performance is categorized into the areas of self-care, productivity, and leisure. Intervention is directed toward the individual's physical, mental, sociocultural and spiritual components of occupational performance within the context of the social, physical and cultural environments. This original depiction continues to evolve (CAOT, 1993). Occupational therapists employ this extensive mandate with a broad scope of client populations across a range of practice settings. Despite, and perhaps in response to the constant threat to the profession of fragmentation and identity crisis (Gilfoyle, 1984), the core concepts of "client-centred practice" and "occupational performance" are emerging as the uniting force for this widely encompassing discipline (Townsend & Banks, 1992).

Teaching: Professional Identity and Core Practice

As a young adolescent searching for a career goal to motivate me through the secondary school years that loomed ahead, I serendipitiously encountered a brochure describing OT. I was instantly captivated. Words describing the discipline -- holistic, quality of life, meaningful activity, independence -- articulated what had been part of my own developing but tacit philosophy. I chose my future and brushed aside puzzled queries about this seemingly obscure profession. A mild concern seeded itself during the admission process and grew in my early days as an undergraduate in an OT program. I could not articulate the essence of OT; I had no vision of what I would become. It was through one of the many "inspirational" lectures aimed at initiating the new class into the professional socialization process that the well known ancient Chinese proverb was quoted: "Give a man a fish; feed him for a day. Teach a man to fish; feed him for a lifetime." That was it. I was to become a teacher; a teacher of life activities. Through my academic training and subsequent years of clinical experience, this conceptualization has remained not only the core of what it means to me to be an occupational therapist, but it has become more firmly rooted.

The therapist as teacher conceptualization is not only a personal one, but one woven throughout the profession's identity. Occupational therapy, from its birth in the early

part of this century to the present, has been concerned with promoting optimal quality of life in its clients (Reitz, 1992), and an important means of working toward this end has been the teaching role of the therapist (Barney, 1991; CAOT, 1993; Crist, 1986; Mocellin, 1992a, 1992b; Schwartz, 1985; Schwartz, 1992). The notion of "therapist as teacher" has been demonstrated to be a valued one (Fondiller, Rosage & Neuhaus, 1990), and has been formally recognized as a professional role (AOTA, 1993b; CAOT, 1993). The teaching-learning process is clearly one of OT's legitimate tools of intervention (CAOT, 1991; Mosey, 1981). It has even been suggested that the "long-term impact of [OT] treatment may depend more on our skills as teachers than on our abilities and techniques that we have developed and refined in years of practice" (Radomski & Dougherty, 1991, p. iv).

Teaching as a therapeutic intervention is not new to OT. One of the profession's founders, Eleanor Clarke Slagle, was a teacher for whom re-education was central to her work with mental patients (Mocellin, 1992b; Reitz, 1992). Educational terminology permeated early writings, and as noted by Schwartz (1992) "the leaders [of early OT] saw a kinship between education and occupational therapy: they referred to those providing service as occupation teachers, they emphasized the importance of teaching capability, and they described the occupation process as educational" (p.15). There was a fundamental ideological

sharing with the educational progressives.

Learning, especially active learning, underlies the broad scope of OT practice across most frames of reference (Denton, 1987) and areas of specialization (Schwartz, 1985). An emphasis on the teaching/learning process, however, is currently dominant in mental health practice. Occupational therapists working with adult clients experiencing mental disorders often construct therapy groups for the purpose of fostering client learning, usually related to independent living skills. Such groups include a combination of methods that are now well-established, especially within psychiatric services that offer occupational therapy programmes (Polimeni-Walker, Wilson & Jewers, 1992).

In my experience as an occupational therapist working in several different areas of the mental health field, I had become increasingly concerned that my attempts at client education were based on little more than intuition combined with trial and error. The accelerating movement toward improving the "client centredness" of professional practice added further fuel to my concerns. Reflecting on my own practice, I was struck by how little I understood the teaching/learning process and felt increasingly uncomfortable "processing" clients in a "leader-centred" manner through educational groups. A review of the profession's literature mirrored my own experience. There appears to be little to address the issue of the educational

process in groups and what does exist is often incongruent with a philosophy of client-centred practice.

Furthering the understanding of group practice as a principal intervention approach from the perspectives of the therapist and the client promises much benefit. Occupational therapy's efforts at substantiating its practice has become paramount in the current times of critical examination of health care delivery in Canada. This is powered in part by consumer demands for accountability and economic demands for efficiency. There are calls for client education researchers and practitioners to strengthen efforts to be client centred in their care (Bartlett, 1989) and, within OT, practice-based research that enhances the understanding of the impact of client-centred guidelines is an identified priority (Townsend, Britnell, & Staisey, 1990). Through this exploration, the understanding it brings, and the reflection it fosters, a foundation for further research is established along with implications for improving the quality of group practice and its consistency with OT's client-centred philosophy.

Problem Statement and Preliminary Research Questions

This qualitative study explored the experience of an occupational therapy group in a mental health setting with an emphasis on the perspectives of the therapist and

clients. As a phenomenological study, it aimed to enhance understanding through description and interpretation (Bergum, 1991). A secondary objective was to examine the extent to which a client-centred approach is evidenced in actual practice.

I entered the research process shaped by my experience as an occupational therapist who has developed and lead a myriad of educationally-oriented groups, and by my recent learning experiences as a graduate student. Through these, I naturally came with questions in mind. Although I agree that one usually can not know enough prior to undertaking the research to be aware of what questions need to be asked (Bogden & Biklen, 1992; Krefting, 1989), I also recognize, as advocated by Miles and Huberman (1994) that all researchers have some orienting ideas and that there is merit in making initial questions explicit. In order to elicit a rich and full description of the essence of the group experience, I expected to explore numerous questions related to content and process, roles, teaching/learning methods and outcomes:

a) How are decisions related to the content, process, and the very existence of the group made?;

b) How does the therapist teach? What is the teacher role?

c) What motivates clients to attend and to participate? How do the clients learn? What is the learner role?;

d) How do the clients and therapist experience the group?;

e) What are the intended learning outcomes? What are the perceived outcomes? How significant are these to the clients?; and

f) How similar/discrepant are the clients' and therapist's perspectives?

As will be further discussed in the description of the study's methodology in chapter four, these questions were not intended to guide the data collection process. The exciting potential in qualitative methods after all, as has been pointed out by Krefting (1989a), is to gain "new" perspectives on "old" issues. The intent in making them explicit is to be open in revealing my preconceptions as a researcher and to provide some initial boundaries or terrain for the study.

Definition of Terms

As key terms arise, their meanings as used in this study will be clarified. Appendix A, an alphabetically ordered glossary of terms, is also provided. This will serve to avoid cumbersome definitions which detract from the text and to facilitate reference for the reader as may be required throughout the paper.

Scope, Delimitations and General Assumptions

It is important to be aware of this study's boundaries and major influencing assumptions in order to be clear on

the nature and the limits of the knowledge that are derived. Additionally, my world view as researcher, as in virtually any research, has had an impact on every related decision (Merriam, 1988). So with this understanding, appropriate interpretation will be facilitated.

The scope of this study was bounded primarily by the nature of the actual group in focus. The process of its selection will be fully explained as part of the methodology (chapter four) and a more complete description will be provided with the results (chapters five and six). The group is offered at a community mental health clinic that is affiliated with a provincial psychiatric hospital. It is called the Community Living Planning (CLP) group and was designed, in the words of the clinic's policy manual, for "stable, low functioning outpatients in need of support or assistance in setting weekly goals related to community living" (p.E-7). The official protocol is included in Appendix B. The understanding that arises from this study was limited primarily to the perceptions and behaviours of the therapist and a few of the clients who were involved in this one group at the point in time in which data collection occurred. These have been interpreted through my experience as researcher.

The approach to this study was naturally influenced by assumptions I hold. Those related to the nature of knowledge in particular may be labelled constructivist (the

details and implications will be more fully outlined in chapter four). Essentially, I believe meaning to be construed with no such thing as a fixed common reality existing. The participants, then, in this research were valued as knowing beings with their own valid realities.

This study has also been influenced by my previous experiences in the area under investigation and my understanding of the situation prior to undertaking this work. I entered with three main preconceptions. First of all, I expected that the educational process would emerge as a dominant theme for all participants. I also expected that client and therapist perspectives of the group experience would be widely divergent, and that the group would demonstrate no more than a token client-centred approach.

Finally, I hold a fundamental assumption and value that propels and influences this entire work. I believe that educational groups hold great therapeutic potential, and that a client-centered philosophy and approach is desirable.

Outline of the Subsequent Chapters

Chapter one has provided an introduction to this study of the experience of an OT group. The purpose was identified and background information and rationale to support the study were provided. The scope and

delimitations of the study and basic assumptions were also presented. In chapter two the concept of a client-centred practice philosophy will be explored and clarified to provide the study's frame of reference. Literature related to educationally-oriented approaches, especially group therapy, will be reviewed in chapter three to establish the current state of knowledge of its practice. The study's methodology will then be described in detail in chapter four. Chapter five begins the presentation of the findings through a re-creation of client and therapist experiences. The group experience is then described according to the researcher's perspective and is critically interpreted from a client-centred perspective in chapter six. Chapter seven concludes with a summary of this research and discusses implications related to practice, further research, theory, the study participants, and to me as the researcher.

CHAPTER TWO: THEORETICAL FRAME OF REFERENCE

Client-Centred Practice

This study was based on a client-centred frame of reference. As such, "client-centred" may be conceptualized as the primary or, perhaps, most visible background mechanism (Reed, 1984) or dominant influence on my world view as researcher (Merriam, 1988). It is drawn from multiple sources: existing philosophy, theory, clinical practice, research findings and my personal experiences. From the client-centred frame of reference stem the basic assumptions which have guided this thesis from its conceptualization, development of purpose and methodology, through to the interpretation and presentation of findings. In order to make these assumptions explicit, this chapter will elaborate on the meaning and context of client-centred practice. A discussion of the place of the concept within OT will be followed by a review of the term's origins and current themes related to its application in health care. The chapter will conclude by emphasizing the importance of understanding the client to realize a client-centred approach.

Occupational Therapy: A Client-Centred Profession

Being an occupational therapist, it is natural that I, as researcher, chose a client-centred frame of reference to guide this study. From the late 1970s to the present, client-centred language has been emerging as a uniting and central force for the OT profession in Canada (Townsend & Banks, 1992). The concept of client-centred practice, however, has been elemental to the profession since its birth in the early parts of this century. Meyer (1922), in articulating the philosophy of what was a relatively new discipline, spoke of the OT role as one of providing opportunities and not prescriptions. He believed that people were able to maintain themselves through being active in life (Gilfoyle, 1984). Core values incorporating equality of rights, freedom of choice, and the value of the individual, were, and continue to be, consistent with a client-centred approach to practice (AOTA, 1993a).

The increasing emphasis on all aspects of client-centred practice is manifested through a recent upsurge in the frequency of its appearance in the Canadian OT literature (Pollock, 1993; Sumsion, 1993; Townsend & Banks, 1992) and at recent professional conferences. Topics range from increasing consumer/client involvement (e.g., Fraser, Finlayson, Letts, & Walls, 1993; Tryssenaar & Hopkins, 1993) to implementing client-centred assessment and treatment

approaches (e.g., Healy & Woodhouse, 1993; Law & Pollock, 1993). Research related to client-centred practice has been identified as a priority for the profession (Sumsion, 1993).

Factors Influencing the Rediscovery of Client-Centred Occupational Therapy

Multiple driving forces behind this increase in the attentiveness to a client-centred approach in OT practice have been recognized (CAOT, 1991; Giloth, 1990a, 1990b; Townsend et al., 1990). The prevalence of chronic disease, little touched by high technology, has increased personal responsibility for health and raised ethical concerns about traditional medical care. There also has been a continued rise in the consumerism movement, especially strong in mental health (Bloomer, 1978). People with disabilities are engaging in consumer advocacy to regain control over their lives (Deegan, 1992).

A shift in the definition of health has also contributed to the reemergence of a client-centred philosophy (Pollock, 1993). There has been a move from a purely medical model viewing health as the absence of disease, through to the World Health Organization's definition of health as a state of well-being to, most recently, an emphasis on function. Function suggests one's ability to achieve desired goals or perform certain activities. Client involvement is implicit in such a view.

This transformation from a medical model to a model of healthfulness fully recognizes clients' influence on their own state of health (Gilfoyle, 1984).

Certainly OT is not unique in its growing awareness and valuing of client-centred practice. Literature in medicine (Boumbulian et al., 1991), nursing (Matheis-Kraft, George, Olinger & York, 1990) and social work (Abramson, 1990) as well as other areas, is increasingly addressing issues related to "patient-centred," "family-centred," "consumer-centred" or client-centred care. Occupational therapy does, however, consider itself a pioneer of client-centred practice (Tryssenaar, Huddart & Babiski, 1993).

In OT, there is, however, a perceived lack of strong professional identity (Mocellin, 1992a), and relative unfamiliarity to the public (McAvoy, 1992). Its numbers are few and its domain is widespread. Health resource constraints and ongoing inter-disciplinary "turf" wars (Fleming, 1991) are forcing OT to re-examine its stance and return to its philosophical roots in order to clearly articulate and "sell" itself as a profession to ensure its survival (Yerxa, 1991). A client-centred philosophy is an integral component of these roots.

This heightened emphasis on client-centred practice is also a manifestation, in part, of a transformation much larger than the profession: Patriarchy is in decline. Occupational therapists, at the profession's inception, were

females who acted under the guidance of predominantly male physicians (Serrett, 1985a, 1985b). Currently, within all allied health disciplines (which have a primarily female composition), the impact of the feminist movement is evident. New values and modes of thinking have moved allegiance away from a biomedical model which stripped the patient of responsibility, to a holistic, self-care model of health (Gilfoyle, 1984) that is more consistent with a client-centred philosophy.

Occupational Therapy Guidelines

It was partly in response to these many influences that the "occupational therapy guidelines for client-centred practice" [referred to as the Guidelines] were first developed through the mid-1980s (CAOT & DNHW, 1983, 1986, 1987) and subsequently published as a consolidated volume (CAOT, 1991). The Guidelines served to popularize the concept within the profession and, as well as increasing awareness, they provided a framework to guide OT practice. Their evolution continues (CAOT, 1993).

The Guidelines developed and presented a conceptual framework that was intended to be applicable to all clinical practice areas. This framework, known as the Model of Occupational Performance, was based on some fundamental assumptions including a belief in the worth of the individual as an active participant in the therapy process,

and in a holistic approach to care that emphasizes the use of therapeutic occupation or activity. A therapeutic relationship as the cornerstone of the client-therapist partnership and the importance of the teaching-learning process within the therapy process were highlighted. The Guidelines also provided specific direction along the stages of OT practice from initial screening to discharge and follow-up, and recommendations related to measuring outcomes.

Although the original Guidelines advanced understanding in OT, they failed to directly address the meaning of client centred or the essence of its practice. A definition of the term was conspicuously absent. The concept of client-centred is argued to be at risk of becoming a motherhood issue (Law, Baptiste & Mills, 1993), with widely differing visions of its meaning. A struggle in OT to identify the essence of client-centred practice continues (Law et al., 1993; Sumsion, 1993), although recent guidelines that address specific parameters concerning mental health OT practice do hold much promise in ameliorating this struggle. The Canadian Association of Occupational Therapists (1994) suggests that "client-centred occupational therapy refers to practice in which clients' experiences and knowledge are central and carry authority within the client-professional partnership" (p.5).

Origins of the Client-Centred Approach

The origins of the term client centred are customarily attributed to Carl Rogers. The birth of client-centred therapy is considered to have occurred at a presentation in 1940 by Rogers where he introduced a fresh and warm orientation to counselling (Barrett-Lennard, 1986). Over the next few years, a new school of theory and practice, described as phenomenological and existential in character, was established. Client-centred therapy, also known as non-directive therapy, evolved as a unified system of thought with Rogers as its leader and principle advocate. A transition to a broad movement began in the mid-1960s with an ever widening circle of applications (Raskin & Rogers, 1989).

There are distinctive characteristics and principles within Rogers' notion of client centred, although Rogers himself encouraged individual approaches of implementing the client-centred philosophy (Raskin & Rogers, 1989). The creation of a growth promoting relationship is fundamental (Rogers, 1951). Upon a foundation of trust, the therapist demonstrates congruence, unconditional positive regard, and empathy. The guiding assumption is that individuals have within themselves resources for achieving self-understanding and change. The therapist role is to provide the climate and relationship within which the client may attain this

goal. Therapy is viewed as a learning process (Rogers, 1951).

It is a testimony to the soundness of Rogers' approach that his ideas have influenced virtually all areas of thought in domains of interpersonal relationships including education (Rogers, 1969, 1983). The essence of the attitude fundamental to a client-centred approach is revealed in the words of Rogers himself as he expressed gratitude to his clients in the preface of his 1951 text: "We hope that this book will be worthy of them" (p.xii).

Themes in Current Client-Centred Health Care Practice

A review of literature related to client-centred practice within health care provides further understanding of its meaning as a frame of reference for this study. The current literature, although diverse, does reveal common themes and issues. To facilitate this discussion, I have organized these into two discussions: themes related to power and the client-professional relationship, and themes related to respecting the client's values. These appear, through the frequency and consistency of their incorporation into the literature, to be characteristic of common understandings and applications of the client-centred concept. Both are grounded in a basic assumption that underlies all client-centered practice; people are viewed as

individuals with rights (Law, Baptiste & Mills, 1993). Each client is recognized as unique with rights related to maintaining dignity and integrity and to decision making in the health care context.

Power and the Relationship

Themes related to power and the client-professional relationship permeate the literature on client-centred practice. The importance of the patient-caregiver relationship in health care has been well argued (Burgess & Burns, 1990; Boumbulian et al., 1991; Kasch & Knutson, 1985; Lloyd & Maas, 1993), and supported by studies demonstrating a link between increased participation in related decision making with program effectiveness (Falloon & Talbot, 1982), improved health status (Abramson, 1990; Kaplan, Greenfield & Ware, 1989), and with reduced costs (Kaplan, 1991). Others contend that without the increased involvement of clients, the health care system is destined to falter (Meisenheimer, 1991). A collaborative relationship seems to be a basic element of client-centred practice. This theme is variously addressed under allied concepts such as client choice, partnership, client participation, and interdependence.

There is the expectation that within a client-centred OT approach, the occupational therapist-client collaborative relationship will be incorporated throughout the entire therapy process (Finlayson & Edwards, 1992). Involvement of

the client in therapy planning has been described as a generic belief and responsibility of OT (Nelson & Payton, 1991). The view of the client as a vital partner in a collaborative relationship with OT has been supported in research (Peloquin, 1990). The very term occupational is defined as "a process of action in which a person is the action agent or the 'doer'" (Gilfoyle, 1984, p.578). Active client involvement is expected, and is beginning to be extended beyond the immediate therapy context even to the point of client collaboration in OT department administrative functions (Bressler & Jessome, 1993; Stoffel & Cunningham, 1991).

Issues related to the traditional domains of power are complex. Collaboration implies a balanced client-therapist power relationship. A need to redefine power as a shared entity, without domination, has been identified by proponents of client-centred practice (CAOT, 1993; Law et al., 1993). A focus on empowerment, although at risk of becoming a "buzzword" in the health care system, attests to the centrality of the concept of power. It generally refers to processes which enable people to "own" their own lives (Gray & Doan, 1990). These are processes in which people are provided opportunities to take control for themselves (Stewart, 1994).

This empowerment concept within a client-centred approach assumes that individuals usually understand their

own needs better than others. This assumption is consistent with a fundamental value of OT that is manifested in the belief that people are able to influence their own state of health (Gilfoyle, 1984). Enablement is defined as the educational process occurring within the client-therapist relationship that helps people to learn about themselves, their situation, and their ability to make decisions which fulfil their sense of purpose in life (CAOT, 1993, p.80). It involves helping people achieve what is important to them (Stewart, 1994). Interpreted at its most basic level, client-centred practice implies working with clients in contrast to doing for clients.

Respect of Client Values

The second grouping of themes that emerge from the literature related to client-centred practice focuses on values. There is an abundance of convincing arguments to support calls for professionals to address the client's unique values, preferences and needs (e.g., Boumbulian et al., 1991; Delbanco, 1992; Donovan, 1991; Kasch & Knutson, 1985). Boumbulian et al., as one example, argued that to best serve patients, the concept of patient-centered care needs to be expanded to incorporate each patient's values. Today, it is not enough for a health care professional merely to "do good" or to try to "avoid evil," although these goals remain vitally important within the ethical

foundation of the provider/patient relationship. We must analyze what is good from within the value system of the patient, moving beyond medical or epidemiologic outcomes that may primarily reflect the caregiver's values.

In OT, the recognition of what is relevant and purposeful to clients is considered an important principle in client-centred enabling (CAOT, 1993). Law et al. (1993) called for intervention to be based on clients' visions and values and on mutual respect. This requires recognition of the therapist's own values so that client choices are no longer viewed as "irrational" but are acknowledged to be based on what is right for that particular client.

Respect of client values is an inherent part of the ethical component of OT clinical reasoning. In the therapy process, client goals must be taken into account, client autonomy respected, and clients empowered to foster treatment choices (Hansen, 1988). Failure to incorporate methods in the assessment process to determine individual client needs has even lead to a Canadian appeal board ruling against a practicing therapist (Gill & Brockett, 1987).

A central feature of client-centred practice only recently being recognized is the context (Law et al., 1993). The client's roles, interests, environments, and culture provide a needed framework through which to understand the client's values.

This discussion of the two central themes consistently

addressed in the client-centred literature is not intended to be comprehensive. It is also clear that this rather simplistic and distinctive presentation is somewhat artificial. The meaning of client centred, by its very nature, is difficult to capture. As was thoughtfully noted by Carl Rogers, "if one wishes to give such a real meaning he [sic] should put his [sic] hand over his [sic] mouth and point" (1951, p.ix). Words are often inadequate conveyers of real meaning. It is not surprising that OT has yet to articulate the essence of its espoused client-centred approach. These core themes, however, do comprise a representation of the essential nature of client-centred practice. As used in this study, client centred refers to philosophies and approaches which are consistent with a client-therapist relationship in which clients truly direct the therapeutic process in a manner compatible with their unique situations and values. Client centred, as such, is the frame of reference through which an OT group in a mental health setting will be examined.

Cautionary Considerations

In adopting a client-centred frame of reference for this study, it is recognized that this choice is based upon the fundamental assumption that client centred is desirable. This assumption is not accepted without discretion. There

seems to be a general reluctance to hold any notion of client centred up to careful scrutiny. A comprehensive critical analysis will not be undertaken, but it is important to be cognizant of the concerns or limitations that were apparent through the literature reviewed.

The first most frequent and perhaps most concerning issue relates to the intentions behind a client-centred approach. Literature addressing the client-centred practice often attempts to promote the approach but, ironically, does not do so with client-centred intentions. Kasch and Knutson (1985), as an example, suggested that nurses adopt a "person-centred" interpersonal orientation rather than one which relies on their position of authority over the patient so that their focus may be on the uniqueness of patients as people. Their misguided intentions were revealed when they applied this information as a "tool of influence." Thus, client-centred approaches become a compliance-gaining strategy. Others also promoted increased client involvement and control as a method of improving compliance (Ruzicki, 1990), or paid particular attention to client understandings for the purpose of "correcting" their "wrong" perspectives (Burgess & Burns, 1990).

Occupational therapy is not without guilt in this regard. An emphasis on the unique interests and abilities of the client has always been advocated but often these considerations have been within the context of motivating

the individual to perform (Burke, 1977). There is the implication that the client needs to be manipulated into performing the therapist's agenda. The inferred assumption that clients should adhere to therapist-driven treatment regimen is not uncommon (Kielhofner & Nelson, 1983). A client-centred approach, paradoxically, may lend itself to being incorporated into persuasive strategies that tend toward manipulation.

In reviewing the client-centred literature, another concern becomes evident. There are widely varying understandings of the degree of control or power held by the client. Approaches range from token involvement of the client (Barton & Scheer, 1975) to presenting the client as fully responsible and involved (e.g., Millsteed, Wallace & McIntosh, 1991). Although this latter end of the span may be more desirable, there is danger then in the possibility of then directing full blame toward the client.

Finally, there are those that portray professionals as automatons serving the client. Boumbulian et al. (1991) focused on the client's needs and concerns as the client defines them. When taken to the extreme, there is the fear that one is sacrificing professionalism by responding exclusively to the client's request (Burgess & Burns, 1990). The ideal collaborative balance seems elusive.

There are obvious difficulties in applying the concept of collaboration to practice. In discussing Rogers'

original view, Barrett-Lennard stated that "client-centered [sic] therapy, far from being a passive, purely reactive process on the therapist's part, involves a very active, concentrated focussing of purpose, attention, skill and energy" (1986, p.205). The client, therefore, does not do all the work. At times, client-centred treatment, as in a study on OT clinical reasoning (Fondiller et al., 1990), is defined as "considering" things like the patient's cultural background and role expectations. Consideration does not equate with collaboration, and can easily slip into tokenism. The current literature is only beginning to address the bridging step between mere consideration and actual collaboration (CAOT, 1993).

There are many further cautions and dilemmas associated with implementing a client-centred practice. Is client centred itself a uniquely western value? The one pertinent study located did support the effectiveness of patient-centred interviewing in one group of non-western people (Henbest & Fehrsen, 1992). How should one proceed when the client's values are not consistent with a collaborative relationship or the client is unable to participate? Such questions are beginning to be addressed. Law et al., (1993) suggested that in such situations the client may need to be re-defined (i.e., perhaps it is not the patient but the family that is the client). Nelson and Payton (1991) have developed a guiding system to maximize the involvement of

the client in the therapy process. An important area to OT practice that is not directly addressed in the literature, however, is the unique considerations when the therapist's relationship is with a group of individuals.

This discussion of some of the cautions and concerns related to a client-centred practice serve to make explicit some of its potential limitations as the study's frame of reference. One further key element requires discussion.

The Client's Perspective

If we are to accept that an equal relationship and practice based on the client's values does capture the essence of a client-centred frame of reference or approach, a pre-requisite becomes apparent -- the therapist must understand the client's perspective. Approaching the client as a unique individual, providing the client with resources required to enable decision making, truly sharing the power and control, and basing the therapy process on the client's values demands that the therapist listen to and understand the client. Therapist perception alone is inadequate. Denton (1987) discussed the "personal bias" common in therapists in terms of the tendency to overestimate (compared to clients' perception) clients' pathology and the tendency to attribute problems to different factors. This becomes patent when comparing the findings from

Schultz's (1994) and Schwartzberg's (1994) studies of the same group. One focused on the members' perspectives and the other on the perspectives of the participant-observer. The members seemed to be less problem-focused and to have a broader scope than the OT researcher. It has been argued that successful treatment can only occur when the professional comes to understand the client's story (Schwartz, 1990). Peloquin's recent research (1993a) powerfully illustrated that illness and disability are charged with meaning. Without this understanding, client-centred practice is unattainable. This intersubjective understanding is complicated, and somewhat paradoxical as professional power itself can undermine the very process of attaining intersubjective understanding (Crepeau, 1991).

The therapist's understanding and appreciation of what is valued and meaningful for the client has been suggested to be the part of the art of practice that is unique to OT (Clark, 1993; Finlayson & Edwards, 1992). Despite this, in OT there is a paucity of literature describing the client's perspective. Some notable exception exist (e.g., Clark, 1993; Hasselkus, 1988; Helfrich & Kielhofner, 1994; Hinojosa, 1990; Strong, Ashton, Chant & Crammon, 1994). Even research which is clearly grounded in a client-centred perspective can neglect the voice of the client (e.g., Hayman, 1993). Research located that did incorporate the mental health client's perspective in OT literature was

flawed (Barton & Scheer, 1975; Harries & Caan, 1994; Polimeni-Walker et al., 1992; Webster & Schwartzberg, 1992). All four attempted to evaluate the attitudes of clients toward OT but their methodologies actually limited the voice of these very clients. Harries and Caan, for example, conducted structured interviews that were developed by therapists. Webster and Schwartzberg did ameliorate a similar weakness in their study through follow-up interviews. Polimeni-Walker et al., however, moved on to discount the client views they sought through their conclusion that clients needed to be informed of the "real" purposes of therapy. Harries and Caan, labelled clients' differences of opinion from the therapists as "misconceptions", but also acknowledge that these may still be valid needs.

It is not unusual in the literature that does compare therapist and client perceptions to find significant differences (Polimeni-Walker et al., 1992). When one does listen to the client, the importance of understanding is further underscored. In recent writings by a person who lives with a long-term mental illness, the loss of confidence and morale experienced combined with lack of listening and understanding by the hospital staff was poignantly described (Garside, 1993a, 1993b). Peloquin (1993a) also identified clients' disappointment when therapists behaviours exclude caring actions. This

accentuates the importance of collaboration and striving for understanding rather than presuming to know a client's priorities. It is not intended to imply that understanding will automatically lead to a client-centred practice. Complex barriers within the client, the therapist, the health care system, and society at large exist. It does seem, however, that without understanding, attempts at client-centred practice are doomed to be at best misguided and limiting and, at worst, harmful to the client.

Summary

A client-centred frame of reference forms the basis of this study. The discussion has revealed some weaknesses in terms of its theoretical substance and its application to practice. A notable gap is that the context of group practice does not appear to have been addressed. Because it does encompass consistent themes and has been embraced by the OT profession, it will serve as a useful lens through which to explore and understand the OT practice of groups in mental health.

CHAPTER THREE: LITERATURE REVIEW

Educational Approaches in Health Care Practice

The value of any study is derived as much from its fit with and expansion on previous works as from its own intrinsic properties (Merriam, 1988). Literature was reviewed to determine how this present exploration of an OT educationally-oriented group in a mental health setting compares to and has the potential to extend current understandings. Essentially, it synthesizes and critically analyzes this area of OT practice as represented in the recent literature in order to provide a context for this study's focus.

Educationally-oriented groups in mental health OT are closely connected to and influenced by educational approaches in other areas of OT and in health care in general. This literature review commences with a broad overview of educationally-oriented approaches by non-OT health disciplines as an introduction to themes that arise in the areas of educational approaches more closely affiliated with this study. The focus then narrows to non-OT educational practices in mental health, as well as the OT practice of educating clients in areas other than mental health. Finally, a comprehensive summary and analysis of OT educationally-oriented groups in mental health practice is

presented.

In the literature, the terms patient, health, and, less often, client education are used. Central to most definitions is the concept of behaviour change although the vision is slowly broadening. Client education has been selected for use within this discussion to distance the concept from the assumptions inherent in the label "patient" and because the focus of this study is more directly on the individual client than is typical of health education (full definitions are included in Appendix A).

Approaches to Education in General Health Care Practice

Educational approaches have likely always been a component of health care. The modern health education movement was birthed in the late nineteenth century (Redman, 1993) and a recent surge in the past two decades was stimulated by a committment to health promotion, spearheaded by the Lalonde Report in Canada (Lalonde, 1974) and related legislation and policy guidelines in the United States (Jenny, 1990; Redman, 1981).

The general health care literature (i.e., physically-oriented health care outside of OT) is replete with works addressing educational approaches. Patient education handbooks often present ready-made teaching prescriptions specific to a diagnostic category (Palmer & Toms, 1986), and

further texts provide theoretical guidance (Glanz, Lewis & Rimer, 1990; Falvo, 1985). It is within the professional journals, however, that the broad scope of approaches to practice are best documented. A synopsis of these will be provided.

Practice

Works addressing educational practice are most abundant in the nursing literature (e.g., Barr, 1989; DeMuth, 1989), but medicine (e.g., Daltroy & Liang, 1991), nutrition (e.g., Brinberg & Axelson, 1990), and other disciplines are amply represented. Approaches are described in a variety of settings from the acute care hospital (Barr, 1989) rehabilitation settings (Brillhart & Stewart, 1989), ambulatory settings (DeMuth, 1989) to the community (Wallerstein & Bernstein, 1988). The learners or clients vary from those with life-threatening illnesses (Barr, 1989) to the well population (Carmody, Istvan, Matarazzo, Connor & Connor,1986), but typically, are grouped according to medical diagnoses, for example, cancer (Blumberg & Gentry, 1991), rheumatic diseases (Daltroy & Liang, 1991) and neurologically injured (Brillhart & Stewart, 1989).

Obviously, the professional who is in the role of educator and the topic area are intimately related. For example, smoking or alcohol information is more likely to be taught by physicians, but weight control by nutritionists.

Much debate exists related to the questionable abilities of many health care professionals in the role of educator (Daltroy & Liang, 1991; Lipetz, Bussigel, Bannerman & Risley, 1990; Luker & Caress, 1989; Maycock, 1991; Noble, 1991; Simons-Morton, Mullen, Mains, Tabak & Green, 1992).

The objectives of educational interventions in health care naturally relate to an intended health outcome. Traditionally, the focus has been on the transfer of information (Quirk & Wapner, 1991). Usually this is disease-oriented and medical treatment information for the purposes of obtaining informed consent (Barr, 1989), preventing disease (Brinberg & Axelson, 1990; Carmody et al., 1986) or to gain compliance. Teaching to improve compliance has been found to permeate the literature (Luker & Caress, 1989), although education is also intended as a treatment itself, for example, in reducing anxiety or improving pain management (Barr, 1989). This focus is shifting as education is increasingly aimed toward enabling patients to participate as members of the health care team (Anderson, Funnell, Barr, Dedrick & Davis, 1991), or even beyond the medical context toward fostering the individual's growth (Kok, deVries, Mudde & Strecher, 1991).

Detailed descriptions of the actual educational interventions are frequently absent (McCain & Lynn, 1990; Simons-Morton et al., 1992). The literature almost exclusively deals with clinical information and, if teaching

methods or techniques are addressed, it is in the form of practical suggestions without theoretical grounding (Padberg & Padberg, 1990). When methods or strategies are described, they usually serve to deliver information with the learner as the passive recipient. Didactic lectures supplemented by printed materials predominate (e.g., DeMuth, 1989). "One-shot delivery" is common (Anderson et al., 1991) that offers single, predeveloped sessions although individualized education programs are increasingly being advocated (Brillhart & Stewart, 1989; Durbach, Goodall, Wilkinson, 1987; Luker & Caress, 1989; Nobel, 1991) and supported by well-designed research (Brinberg & Axelson, 1990; Donovan, 1991).

The emphasis on methods is often on teaching rather than education. Even within many definitions of patient education the focus is on imparting information (c.f. Luker & Caress, 1989). This emphasis has not escaped criticism. Noble (1991), for example, denounced the "passing on facts" approach and calls for the client to be engaged in learning; Wilson-Barrett (1988) advocated for use of non-directive approaches that emphasize the facilitation of learning.

There is extensive literature addressing inadequacies of client education programs (Lipetz et al., 1990), and evaluation of these programs in general health care is itself the target of criticism. Major problems in existing research have been identified including flaws in basic

rationale (Simons-Morton et al., 1992), poor design and control of interventions (Lipetz et al., 1990) and flaws related to outcome measures (Donovan, Blake & Fleming, 1989; Luker & Caress, 1989; Oberst, 1989). Some well designed studies (Brinberg & Axelson, 1990; Carmody et al., 1986) and literature reviews (Daltroy & Liang, 1991) do exist that suggest the effectiveness of educational approaches but equally common are those with inconclusive or conflicting results (McCain & Lynn, 1990; Noble, 1991).

Theoretical Base

In the forward of a prominent health education text (Glanz et. al., 1990) is the comment that "one must wonder why so much practice in health education is atheoretical" (p.xix). Others also reach this conclusion (Oberst, 1989; Padilla & Bulcavage, 1991), and this current literature review concurs. Many of the program descriptions lacked any reference to theory or provided only a cursory theoretical base. This is difficult to account for as there is a substantial body of theoretical works in the literature to guide approaches to education in health care (e.g., Glanz et al., 1991). There are, however, examples of "custom" models, developed for specific programs (Blumberg & Gentry, 1991), and rather eclectic combinations of models and theory (Den Boer, Kok, Hospers, Gerards & Strecher, 1991; Padilla & Bulcavage, 1991; Rosenstock, Strecher & Becker, 1988).

A salient feature of theory in publications related to health education is that it tends to exclusively address health-related decisions and behaviours. Theory to address the teaching/learning process is conspicuously rare. Patient education texts do tend to draw on educational theory; however, its superficial presentation is overshadowed by a strong clinical emphasis (Redman, 1993). Direct application to client education practice is rare. Some exceptions were noted including the application of Kolb's typology of learning styles (Hartley, 1988), types of educational approaches (Armstrong, 1989), and types and categories of learning (Maycock, 1991).

Learning theory seems to be rarely addressed; however, adult education theory seems particularly scarce. In one eminent client education nursing resource, for example, only a single page of the text is allotted to adult education (Redman, 1993). The term adult education has been found to be unknown to many health professionals (Ash, 1985).

There are, however, rare but notable exceptions to this "rule". These are primarily found in the nursing literature. Yoder Wise (1979) incorporated adult learning factors (i.e. Knowles and others) and adult development (i.e. Havighurst) in her recommendations for client education. Goodwin-Johansson (1988) discussed several works from adult education, with an emphasis on Knowles' principles of andragogy, and highlighted the dichotomy

between adult learning theory and current client education practice. Gessner (1989) presented adult education (i.e. Knowles, Merriam, Knox, Tough, Brookfield, Cross) as an essential "high quality ingredient" for client education. Fahrenfort (1987) discussed the implications of Freire's empowerment theory on patient education, and Wallerstein and Bernstein (1988) advanced Freire's ideas beyond the abstract to a well articulated clinical application.

The incorporation of educational theories would seem to be appropriate and necessary to substantiate client education practice, but doubts have been expressed regarding the transferability of mainstream educational principles, especially adult learning theories to patient education (Luker & Caress, 1989). There are calls in the literature to develop theory specific to patient education, whether exclusively from health disciples (Smith, 1989) or from other fields including education (Oberst, 1989)

Summary

In the literature related to client education practice in general health care, actual descriptions of practice were outweighed by theoretical or prescriptive works. Educational approaches seem to be usually directed at learners who are categorized according to medical diagnosis. Although there is evidence of some changes, typically, the

transfer of disease or treatment-oriented information for the purpose of gaining compliance is the emphasis. Within descriptions of practice there is a preponderance of ready-made, one-directional strategies, and although usually details of methods are absent, there is often an extensive detailing of content. Practice descriptions typically did not explicitly address the approaches' theoretical basis, and when theory was addressed it was related to diagnostic information. Educational theory was noted to often be conspicuously absent.

Educationally-Oriented Approaches in Mental Health

Educational approaches in mental health outside the domain of OT are the focus of this second part of the literature review. Education is recognized as an important aspect of treatment for psychiatric illness (Anthony & Farkas, 1982; Daley, Bowler & Cahalane, 1992). Because the boundaries between treatment, rehabilitation and education are often blurred, defining the literature search is difficult. For this review the focus was on works that explicitly emphasized education as either an intervention or an objective of the approach.

Educational interventions in mental health have been growing in popularity through the 1970s and the 1980s to the

present. Although influenced by factors affecting health care in general, this trend stems more directly from attempts to respond to the deinstitutionalization of the 1960s and 1970s (Gingerich et al., 1992) by training family as caregivers. A shift from insight-oriented psychotherapy to supportive approaches, decreased lengths of hospitalization, and increased knowledge of the factors involved in psychiatric illness (Daley, Bowler & Cahalane, 1992) also explain the growing popularity of educational interventions. Most often in mental health, educationally-oriented approaches are labelled "psychoeducation." Prior to proceeding with an overview of practice, it would be helpful to first clarify the meaning of this term.

Psychoeducation

There is no agreement in the psychiatric literature on the definition of the term psychoeducation (Daley et al., 1992) despite its wide and often discrepant use. This vagueness has been criticised (Hatfield, 1986), and efforts to establish definitions are abundant. Goldman (1988), for example, suggested its use be limited to "education or training of a person with a psychiatric disorder in subject areas that serve the goals of treatment and rehabilitation" (p.667). This exclusion of non-patients contrasts sharply with others who conceptualize psychoeducation as being limited to family education (Gingerich, et al., (1992).

Walsh (1992), avoided this issue in his definition of psychoeducational programs "as time-limited, closed groups conducted by mental health professionals for the purposes of educating and providing support to a lay membership" (p.205). These limitations of structure, educator and purpose, however, exclude many programs that purport to be within the psychoeducation domain. Ascher-Svanum, (1989) stated that "the term `psychoeducational' refers to the use of educational techniques, methods and approaches to aid in the recovery from the disabling effects of mental illness" (p.82) whereas others (e.g., Bernier, 1992) emphasized its applicability at all stages of health and illness. Variations in the definitions appear to be almost as plentiful as variations in the approaches labelled as psychoeducational.

Despite these variations, there are some commonalities. Usually, there is a focus both on imparting information as well as helping participants develop coping skills (Daley et al., 1992). Psychoeducation frequently refers to structured programs which focus on specified content areas usually aimed at ameliorating skill deficits through providing training experiences (Lillie & Armstrong, 1982). As the term suggests, there is a psychological and an educational focus (Bernier, 1992). Psychoeducation, then, is more than information acquisition as was prevalent in general health care's educational approaches.

Not all works in the mental health literature that take an educational perspective use the term psychoeducation. Nemec, McNamara and Walsh (1992), for example, differentiated between two methods of skill development which they labelled as skills training and direct skills teaching. There are also attempts to develop a therapy as learning perspective (e.g., Gould, 1990) and teaching as treatment (Carkhuff & Berenson, 1976). Both imply a broader perspective than psychoeducation. There are also areas of practice that do not espouse an educational approach but, upon closer scrutiny, clearly aim toward a specific skill training. Anger reduction treatment is but one example (Deffenbacher, McNamara, Stark & Sabadell, 1990; Deffenbacher & Stark, 1992; Deffenbacher, Story, Stark, Hogg & Brandon, 1987).

Practice

Virtually all disciplines involved in mental health care have been reported leading client education interventions. Psychologists, social workers, rehabilitation counsellors and, most commonly, the psychiatric nurse (Mohr, 1993), as well as non-health disciplines such as university faculty (Cleary, 1992) and former student volunteers (Bakker & Armstrong, 1976) are described in a teacher role. In contrast to the physically-oriented literature, only one work was located (Goldman,

1988) that actually debated the quality or ability of the educator in mental health.

Educational approaches are practiced in settings that vary from acute care inpatient psychiatric hospitals (Ascher-Svanum, 1989), to chronic psychiatric facilities (Boyd, Morris, Turner & Little, 1991), to non-psychiatric institutions such as surgical wards (Devine, 1992) or colleges (Cleary, 1992), and even private homes (Walsh, 1992). For the most part, people experiencing any one of the range of psychiatric illnesses such as schizophrenia (Ascher-Svanum, 1989; Greenberg et al., 1988), affective disorders (Daley et al., 1992), eating disorders (Connors, Johnston & Stuckey, 1984), and alcohol abuse (Carver, Kittleson & Andrews, 1991) as well as their families (Gingerich et al., 1992; Walsh, 1992) are the typical learners. There is also a growing number of mental health educationally-oriented programs for the "well" population (Cleary, 1992).

The objectives of educational programs in mental health, as was noted in health care literature, frequently aim to foster compliance (Antai-Otong, 1989; Ascher-Svanum, 1989; Goldman, 1988). Non-compliance with medication regimens, the primary medical treatment of most psychiatric illness, is described as a major problem. The acceptance of compliance as an aim, however, has been challenged (Anthony & Farkas, 1982) with recognition of potential negative

outcomes to the compliant client, often related to quality of life issues.

Often goals extend beyond imparting information regarding the illness and treatment, as was characteristic of the literature reviewed, to also address enhancement of daily living skills (Greenberg et al., 1988; Nemec et al., 1992). A review of the literature related to affective disorders (Daley et al., 1992) found that purposes included decreasing specific illness symptoms, reducing family burden and stress, increasing hope, helping participants to acquire new coping skills, facilitating specific cognitive, affective and/or behaviour change, and providing emotional support as well as enhancement of treatment compliance. These aims seem consistent regardless of target group. Bernier (1992) identified such widely ranging aims of psychoeducation programs as minimizing anxiety in people with cancer, offering support care in HIV infection, prevention of child abuse, cocaine relapse prevention and others.

Combined didactic-experiential methods presented in a group setting are the "modus operandi" of educational practice in mental health. Often a formal curriculum or structure is developed and implemented through lectures, discussion groups with specific topic focus, and practice opportunities (Bakker & Armstrong, 1976; Daley et al. 1992; Greenberg et al. 1988; Lillie & Armstrong, 1982; Mohr,

1993). The specific educational methods or strategies are usually not well detailed in program descriptions in the literature. Even authors such as Bower (1989), for example, who purported to describe the teaching of "self-regulation" (e.g., muscle relaxation, yoga, biofeedback) offered brief overviews of each technique with no clear guidance on teaching methods. This is contrasted by rare works, such as Nemec et al.'s (1992) thorough presentation of elements and methods of implementing direct skills teaching.

Evaluation of Outcomes

In some literature, evaluation is neglected (Stern, 1991a) or not available at the time of publication (Bakker & Armstrong, 1976), but generally, mental health literature commonly addresses evaluation of the educational approach's outcomes. The consistency of positive findings is surprising, and perhaps even disconcerting.

Educational interventions have been shown to decrease suicide rates and improve family functioning in patients experiencing affective disorders (Daley et al., 1992) and significantly improve psychological functioning (Connors et al., 1984). Results of a study of women with bulimia (Connors et al., 1984) indicated a decreases in binge/purge behaviour, depression, and pathological attitudes related to eating as well as improved self-esteem and assertiveness. Effectiveness research has also been published related to

mental health outcomes (e.g., psychological distress or coping) in physically-oriented areas of health care such as surgical (Devine, 1992) and cancer patients (Cunningham & Tocco, 1989). One volume of the journal "Patient Education and Counseling" (1992, volume 19), dedicated exclusively to psychoeducation research, inordinately supported the approach. One is left with the impression that psychoeducation is a panacea that can enhance virtually anything. Bower's review (1989) of research studies related to teaching the elderly self-regulation techniques, is one of the rare works that question the quality of outcome research. She questioned the validity of most studies because of their weak research designs.

The present literature review supports this concern. Such basic considerations as including a control group or conducting follow-up to determine if effects are maintained are routinely not carried out (Connors et al., 1984). Even rare attempts at evaluative research which do incorporate these considerations (Deffenbacher et al., 1990), are weakened by methods of participant selection.

Another literature review (Wallace et al., 1980) of social skills training literature (i.e. assertiveness training, structured learning therapy, etc.), also found that many studies did not include significant numbers of patients and often the positive results were not generalized to new situations. The total duration of most teaching,

they noted, was often less than 10-20 hours which is likely insufficient for significant learning to occur. Other weaknesses were also discussed but most concerning was their observation that studies often did not indicate a substantial difference in patients' quality of life. This suggests an issue more troubling than methodological concerns.

Anthony and Farkas (1982) extended this discussion to outcome research in general in the mental health population. Assessments of interventions traditionally focus on outcomes related to treatment objectives. They suggested that goals achieved may be at the expense of outcomes not considered. They provided an outcome assessment model that aids in examining not the acquisition of a skill, for example, but the effects on that person's life resulting from acquiring that skill. Outcomes are defined by the client. Walsh (1992), through his review, concurred. In recognizing the value of qualitative methods, he concluded that most of the research he reviewed seemed "compelled" to focus on statistical methods that miss the essence of important change. Walsh suggested that the focus be on outcomes relevant to the program participants. He expressed concerns that psychoeducation will "continue to flourish" with little direct evidence of positive outcomes for the participants. Design flaws, a near absence of qualitative methods, and a neglect of client goals necessitate much skepticism in the

acceptance of the abundance of reported positive results.

Theoretical Base

The theoretical base upon which client education practice in mental health is grounded, as with health care in general, is often not described in the literature. An obvious medical orientation, evident in attempts to foster compliance, is common but not typical. Educational approaches in mental health practice often reject traditional models of psychiatric intervention. A major assumption is that problems are primarily a result of social learning, not illness, and that the same learning process can be used to resolve the problems.

It seems it is assumed that by characterizing an approach as psychoeducational, an adequate theoretical base is implied (Gingerich et al., 1992). As has been presented, however, psychoeducation is little more than an umbrella term that does not approach the level of theory.

When a theoretical base or rationale is provided, it is often through a model or combination of models not specific to educational interventions. Most common are the incorporation of a psychiatric rehabilitation model (Anthony & Farkas, 1982) and cognitive-behavioral models (Deffenbacher et al., 1990). Connors et al. (1984), for example, described a structured group education treatment for bulimic patients which incorporated an eclectic mix of

theories or models to link aims and methods.

Teaching/learning theories and educational references are consistently absent. In the more physically-oriented health care literature, many exceptions to this rule were noted; however, no practice descriptions were located in the mental health literature outside of OT that drew from educational theory. This is surprising considering the common understanding of psychoeducation as a combination of psychological and educational approaches. The approach most consistent with an educational model was described by Bakker and Armstrong (1976). This "school for behaviour change" was stated to be based on an "educational" model. Participants were called students and staff were instructors. The program was even located adjoining a university campus. Despite the labels, no explanation of the model was provided and of the two references in this descriptive article, neither supported the espoused educational theory base.

Summary

Educational approaches in non-OT mental health practice have been shown to be quite similar to those in general health care. There does, however, appear to be a greater acceptance and use of educational interventions. The literature reflects this in an increased proportion of

practice descriptions compared to theoretical discussions. Structured, didactic/experiential combinations which are characteristic of the psychoeducation model or approach predominate. These are typically professionally directed, non-individualized approaches that offer little control to the client. There continues to be an emphasis on compliance, but there was a general sense of increased value of the client's perspective. Evaluation of the effectiveness of educational interventions is extensively addressed; however, the quality of much of the research is poor. A paucity of theoretical support for the educational approaches has also been identified.

Client Education in Occupational Therapy

The third category of literature reviewed in this exploration of educationally-oriented approaches is literature related to OT practice outside the area of mental health. As was described in chapter one, the teaching/learning process is central to OT practice, so as would be expected, references to the practice of educating clients are plentiful in the professional literature. Much of this is so intimately incorporated into any works pertaining to the therapeutic process, that it is difficult to separate educational practice as a distinct entity. This review focused on papers that explicitly addressed client

education, especially through groups, as a specific therapeutic intervention.

Practice

Educational approaches in OT are directed toward a range of learners as broad as the profession's mandate. As with non-OT practice, educational approaches are utilized in acute medical settings, with, for example, heart transplant recipients (Shotwell, 1991) and burn victims (Kaplan, 1985). More common, however, are educational programs designed for people with chronic disabilities, often in a rehabilitation setting. People with spinal cord-injuries (Cunningham & Kelsch, 1991), post-polio sequelae (Young, 1991), cognitive disabilities (Mann & McKinley, 1991), physically disabled adolescents (Bell & Quintal, 1985) and, frequently, people with arthritis (Bowell & Ashmore, 1992; Cartilage, 1984; Furst, Gerber, Smith, Fisher & Schulman, 1987; Healy, 1991) are some examples. Increasingly, however, OT is working with clients beyond the traditional medical patient definition. This is reflected in such education programs as those aimed at families of people with spinal cord-injuries (Cunningham & Kelsch, 1991), parents of disabled children (Lynch, 1986), and caregivers of people with dementia (Butin, 1991). Older learners are also targeted: the well elderly in community settings (Barney, 1991), in retirement settings (Herring, 1989), and the elderly in nursing home

settings (Breen, 1989). Educational approaches are also directed toward younger healthy populations: a much more prevalent practice than was noted in the non-OT literature. The legion of programs for employees in the workplace are evidence of this (Allen, 1986; Carlton, 1987; Jaffe, 1989; Kaplan, 1986; Kaplan & Burch-Minakan, 1986; King, 1993; Mungai, 1985; Schwartz, 1989). One of the more unique programs described was for non-dysfunctional, nondisabled members of a native Canadian community (DeMars, 1992). A range from individual patients in acute medical settings through to entire well communities is targeted through OT educational approaches.

Occupational therapists often share the role of teacher with another therapist or with other members of the health care team (Furst et al., 1987; Shotwell, 1991), and occasionally, with lay staff (Bell & Quintal, 1985). Typically, other than labelling who, by discipline, is involved, little else related to the role of the teacher is discussed. Although scarce, there are some program descriptions that briefly and broadly noted issues of training (Bell & Quintal, 1985; King, 1993), personal learning required (Breen, 1989) or collaboration with an educator (DeMars, 1992; Mellenthin-Seeman, 1987). Discussion about the knowledge, skills and attitudes required to be an effective teacher are usually the domain of more theoretically-oriented works (Ager, 1986; Hasselkus,

1983; Kautzmann, 1991). Generally, however, it seems uncritically accepted that being a therapist infers the ability to be a teacher.

Objectives of educational approaches in OT generally are encompassed within the profession's aim, that is to maintain, restore and promote optimum function. This may relate to specific activities of daily living (Palmer & Toms, 1986) or general life-style change (Kaplan, 1986). Educational intervention usually is directed toward more narrow objectives related to, for example, learning the use of community resources (Marken, 1991) or educating patients about their condition and ways of coping (Young, 1991). Frequently, the focus is on vocational performance. There were descriptions located, among others, of industrial injury prevention (Schwartz, 1989), vocational preparation (Mann & McKinley, 1991), and health promotion in working environments (Allen, 1986; Jaffe, 1989). An increased OT role in disease prevention and health promotion is being advocated (Jaffe, 1986; Rider & White, 1986), and education is seen as one of the primary means through which this is achieved (Johnson, 1986).

As within the general health care literature, there continues to be client education related to medical interventions. Teaching of coping mechanisms to alleviate anxiety at the time of gold injections in children with arthritis (Healy, 1991) and minimizing adverse effects of

bedrest and promoting cardiovascular conditioning in surgical patients (Shotwell, 1991) are two examples within the OT literature. Compliance-gaining aims, although much less prevalent, are still present (Cartilage, 1984; Kaplan, 1985).

The near prototypic educational methods applied in OT are well illustrated through Bell and Quintal's description (1985). Their approach included a series of structured group sessions which combined didactic theory and experiential activities. A planned curriculum is the rule and most descriptions emphasize content taught, at times with detailed specifications of what was covered in each class (Allen, 1986; Cunningham & Kelsch, 1991). Informal, loosely structured programs, such as one aimed at helping people learn to use the public library (Marken, 1992) are the exception. There are varying degrees of balance between those with a high proportion of didactic instruction such as verbal lectures, written or audiovisual information (Allen, 1986; Kaplan, 1985), and those with more emphasis on such methods as group discussion, role play, workbooks and direct experiential means (Mann & McKinley, 1991; Young, 1991). Occasionally, such as in one workplace program which provided instruction under actual employment conditions (Schwartz, 1989), a heavy emphasis is placed on practice. Unfortunately, there is usually a lack of sufficient detail of methods to allow modelling of the educational approaches.

Evaluation of Outcomes

Evaluation is routinely addressed in the OT literature (DeMars, 1992; Dortch & Trombly, 1990; Young, 1991). This may consist of a minor mention, for example, of "supportive quizzing" of material presented to patients (Shotwell, 1991), through to formal research designs. Some examples of the latter include Furst's (1987) study of the effectivness of two different energy conservation education groups, Dortch and Trombly's (1990) comparison of groups of individuals at risk of hand trauma, and Carlton's (1987) study of instruction in body mechanics. Once again, attempts at evaluating outcomes of OT educational approaches often suffer methodological weaknesses that preclude acceptance of their results (Elias & Murphy, 1986).

Less formal outcome research, however, is more common. Virtually all program descriptions address evaluation whether through "homegrown" participant questionnaire (Bowell & Ashmore, 1992), through pre and post course interviews (Lynch, 1986), or feedback related to attendance and participant comments (Breen, 1989). Strongest in credibility are reports of participants demonstrating the intended learning (Marken, 1991). Unfortunately, some discussions are limited to subjective impressions of the author that lack credibility when taken in the context of the numerous serious problems identified (Allen, 1986).

Theoretical Base

In the review of health care literature, a preponderance of works addressing theory to support or guide education practice was noted. Actual descriptions of practice, however, were characterized as often atheoretical. Virtually all practice descriptions in the OT literature, however, have an articulated theory base or, at minimum, a rationale to support their approach to education. This support often takes the form of a specific practice model.

One model, commonly applied in OT, is the YWCA life skills model (c.f. YWCA, 1986). This model assumes that problem solving, goal setting, decision making, and personal and interpersonal skills are prerequisites to successful life management. It is comprised of highly structured group sessions that incorporate theory and experiential activities. A standard format is followed for each group. Bell and Quintal (1985) based their program for physically disabled adolescents on the life skills model. They provided detailed descriptions of the application of the model and incorporated additional research findings related to promoting self-esteem.

Another example of the type of model applied in OT client education practice is one that Furst et al., (1987) used in their rheumatoid arthritis education program. This model, known as PRECEDE (an acronym for predisposing, reinforcing, and enabling causes in educational diagnosis

and evaluation), was used to define and priorize educational objectives and to define outcome behaviour. The model works through a six-stage deductive process that starts with what is "wrong" and works through to the potential solution. Healy (1991) provided a third example of the kind of theoretical models applied in OT client education in her description of teaching guided fantasy as a coping mechanism for children. She based the approach on the process of Neurolinguistic Programming, which, although not a tested theory, promotes itself as a practical method to help people change. It aims to produce change in thoughts and behaviour and to provide a sense of control.

Occupational therapy, which rarely adopts a purist approach to any therapeutic intervention, often also approaches client education in an eclectic manner. DeMars (1992) illustrated this tendency. In her well articulated description of the theoretical basis of a life skills, community-based prevention/wellness educational program, she drew from sociocultural systems theory, anthropology, and developmental cognitive-behavioral learning theories. More frequent, however, is the reliance on a literature review to serve as the particular program's rationale and, usually, this only supports the content and not the educational approach (Allen, 1986; Carlton, 1987). As Hasselkus (1983) has noted, "educators are well versed in the conceptual bases but not the content of patient education and health

providers are versed in the content but not the conceptual bases!" (p.68).

When the approach to teaching or the educational process is addressed, the emphasis is usually on cognitive and behavioral theory. This is evident in practice described in the literature (Johnson, 1987), as well as professional texts' approaches to discussing teaching/learning (Schwartz, 1991b). Other texts offering theoretical guidance have a strong neurobiologic emphasis (Schwartz, 1985).

Many areas of client education literature in health care reviewed thus far were found to essentially ignore educational theory. This is less true in the OT literature. It has been recognized that regardless of the OT model used, the therapist needs to have an understanding of educational theory (King, 1993), and thus it is often, although not routinely, encountered. Schwartz (1989), founded her industrial injury prevention educational program on principles of educational psychology. Barney (1991) frequently referenced adult education theorist Knowles in her discussion of educational strategies to promote health with the well elderly. Marken's (1991) activities for the developmentally-disabled participants were selected using principles of the teaching-learning process described by Mosey, an OT theorist. Rather typical, though, were token mentions of education theory such as Cunningham and Kelsch's

(1991) brief explanation of the three domains of learning. Their primary reference for "education theory" was a nursing patient education text. Cunningham and Kelsch are not alone in inadequately supporting their attempts to provide a solid educational conceptual base. Furst et al. (1987) claimed in their educational package to incorporate learning theories, principles of educational psychology and behavioral modification techniques, although not a single reference supported this claim.

Although the focus of this review was on works directly related to clinical practice, it was noted that some of the more theoretically-oriented discussions did make notable efforts to draw on educational theory. Hasselkus (1983) argued that accurate transmittal of information is only one part of the education process, then proceeded to discuss basic principles of adult education. She focused on the concept of life span development based on the works of Knox and others. Kautzmann (1991) also attempted to integrate educational theory into OT. She suggested that "planning, organizing, and implementing effective patient education programs requires that occupational therapists add knowledge and understanding of adult learning theory and its application to program design to their repertoire of clinical skills" (p.10). Drawing from several adult education theorists, most notably Knowles, her discussion included descriptions of the characteristics of the adult

learner, the factors affecting learning readiness, and conditions of learning and principles of teaching. She specifically addressed issues related to integrating education into the OT treatment plan.

Summary

Occupational therapy educational approaches outside the mental health practice area have been described as occurring across a broad range of learners and settings. Typically a structured group with didactic and experiential methods are employed although there is less emphasis on the instructor-directed methods than in the general health care literature. Outcomes are usually addressed, but methodological weaknesses are apparent. Although theory and practice models were consistently used to support and guide the intervention, there continued to be little attention to educational theory.

Educationally-Oriented Groups in Occupational Therapy Mental Health Practice

This final section of literature reviewed directly relates to this research's focus on the OT mental health practice of educationally-oriented groups. As with the framework established in the preceding sections, an overview

of practice will be followed by considerations related to outcome and to theoretical bases.

The educational process seems more closely aligned with OT practice in mental health than in the other areas of the profession's practice or to health care in general. A central philosophical tenet of OT, "to learn by doing" (Lillie & Armstrong, 1982), becomes especially germane to this area of practice when considering the professional assumption that "mental health is achieved through the learning of new adaptive skills and/or the unlearning of old maladaptive habits" (King, 1978, p.16). Expressed simply, OT is concerned with helping individuals learn the skills necessary for daily living; the teaching-learning process is central in developing living skills (Crist, 1986).

Practice

Educationally-oriented groups in mental health OT do not differ markedly in terms of clients and aims from educational approaches in general mental health. Clients represent the scope of mental health/illness, but most descriptions of practice are aimed at people with psychiatric diagnoses from psychiatric inpatients at a minimal level of functioning (Kaplan, 1986) through to those with chronic illnesses but at a high functional level (Nickel, 1988).

The most common objectives of educationally-oriented

groups are related to life skills. Most often the teaching of life skills was with seriously emotionally disabled (Lillie & Armstrong, 1982) or chronic psychiatric patients (Mauras-Corsino, Daniewicz & Swan, 1985). Often the educational approach was presented as a "package." Some examples are an assembly of stress-management, assertiveness training, goal-setting, parenting skills, financial management, time management, and problem solving (Gusich & Silverman, 1991) a combination of health education, communication, exercise, leisure activity and a community transition (Neville-Jan, Bradley, Bunn & Gehri, 1991) and instruction in interpersonal, problem-solving and self-management skills (Johnson, 1987). Life skills topics were also more narrowly focussed such as education related to anger management (Grogan, 1991), self-esteem (Stoffel & Cunningham, 1993), and nutrition education (Bernard & Therriault, 1986; McDougall, 1992).

The second most commonly described topic of educationally-oriented groups, considered by some as a category of life skills, is stress management. Stein and Smith (1989) provided one example with depressed inpatients. The program was based on the assumption that one's reaction to stress is determined by a combination of one's inner resources and one's support network. The aim was to teach individuals to learn how to cope more effectively with stress by providing exercises and techniques, increasing

social skills and self-esteem and providing support. Other examples of teaching stress management are directed toward people with schizophrenia (Stein & Nikolic, 1989), general psychiatric outpatients (Griffin, Ling & Staley, 1985), and with people dealing with anger (Taylor, 1988).

The third common grouping of topics "taught" in OT groups, again often classified as a type of life skill, relates to what is variously labelled interpersonal (Bruce & Borg, 1991; Denton, 1982) or communication (Brown & Carmichael, 1992; Nickel, 1988) or social skills (Brady, 1985; Davis, 1983).

Occupational therapy groups in mental health customarily focus on skills directly related to occupational performance, but there are beginning to be calls to the profession to broaden this. For example a need to "teach" skills required to become empowered has been identified (Woodside, 1991). Only one description of such a program was located (Millsteed, Wallace & McIntosh, 1991). It was developed for women in the community with eating disorders.

The facilitator or leader role in educationally-oriented groups described in the OT mental health literature is at times shared with another occupational therapist (Brown & Carmichael, 1992; Stein & Smith, 1989) or more often, a person from another discipline (Greenberg et al., 1988; Kaplan, 1986). There were some unique programs in terms of leadership, such as one in which the OT

collaborated with members of a networking organization for professional business women to provide client education (Mauras-Corsino et al., 1985). Most often, however, the role is not addressed so it may be assumed that the occupational therapist single-handedly facilitates. As within the general OT literature, issues associated with the competency of the educator were virtually ignored. There were some brief mentions, however, that new staff were trained in educational techniques (Greenberg et al., 1988), or recommendations that therapists participate in a similar group prior to leading one (Johnson, 1987).

The focus of this section of literature review is on groups as a specific educational approached because groups are by far the predominant teaching method (Bradlee, 1984; Mauras-Corsino, 1985; Neville-Jan et al., 1991; Nickel, 1988). Only one example of teaching an individual was located in this review (Stein & Nikolic, 1989).

There seems to exist a near prototypic framework for the format and methods employed in these groups. Several examples will illustrate. One typical approach is Griffin et al.'s (1985) stress management program. A two-hour meeting was offered in an outpatient setting once a week for ten consecutive weeks. Each session was structured as follows: relaxation training (30 minutes), goal setting (15 minutes), and a didactic portion (45 minutes). Patients learned relaxation techniques and stress management skills

such as life style change, and cognitive restructuring. Homework consisted of reading, maintaining a log, and practicing exercises. Another example is an assertiveness training program (Brown & Carmichael, 1992) which met for a seven week series of one and a half hour sessions twice weekly. The first hour was formal instruction in a specialized skill (e.g., refusing requests) and activities such as role play to facilitate the learning process. The last half hour was designated for socializing. The last example of typical methods employed is provided by Greenberg et al.'s (1988) life skills program. Formal instruction and task-oriented techniques were combined in a series of five weekly classes supplemented by one-on-one tutorials. Topics such as goal setting, stress management, social skills, self-care, home management, leisure-time planning, and using community resources were addressed. Methods listed included group discussion, lectures by staff and patients, role playing, simulated tasks, video and audio tapes, computerized and paper/pencil exercises, reading assignments, and homework assignments.

An atypical example because of its large scale was a life skills program described by Lillie and Armstrong (1982). The program was formed as a school with a monthly schedule of classes, seminars and activity groups. The occupational therapist was the program coordinator and varied disciplines "taught" the classes. It was reported

that more than one hundred different syllabi of structured learning classes were developed. Each course included both didactic and experiential approaches, usually oriented toward specific skill deficiencies such as relaxation exercises, prevocational skills and so forth.

It has been noted that groups including this kind of combination of task-oriented activities and didactic teaching are well-established within occupational therapy psychiatric services (Polimeni-Walker et al., 1992). There are some attempts to de-emphasize the didactic ingredient of this formula. An OT text, in which selection of teaching methods is detailed, for example, includes considerations related to such methods as explore and discover, role play, problem solving, projects, and so forth, but purposely omits lecture and other didactic methods (Denton, 1987). They are, however, still surprisingly prevalent considering the profession's guiding assumptions related to active learning.

A few exceptions to the highly structured task/didactic group approach were located. Millsteed et al. (1991) discussed an educationally-based ongoing self-help group which utilized casual meetings without pre-determined content or structure. Mauras-Corsino et al. (1985) described a five-session series of seminars on community living and work readiness held by a club of successful working women for women with chronic psychiatric illnesses. Denton (1982), as a final example, described a creative

approach to teaching social skills. One and a half hour sessions over seven weeks were used by participants to produce an interpersonal skills videotape. Participants decided on relevant topics, wrote the script and served in all roles in the tape's production.

Evaluation of Outcomes

Each description of educationally-oriented practice in OT mental health located in this review did address outcome of the intervention in some manner. Subjective or self-assessment was often incorporated. Nickel (1988), for example, based on a subjective evaluation, concluded that conversational skills did appear to improve following the group. Greenberg et al.'s (1988) patient self-assessment following a life skills series, indicated a gain in sense of self-satisfaction.

Other literature addressed outcome evaluation of educational groups through a more formal means. There were large scale reviews, such as Brady's (1985) review of experimental studies of social skills training in varied psychiatric populations which clearly indicated a need for further research. Some evaluated the effectiveness of a specific program. Most of the literature, such as McDougall's (1992) assessment of the effectiveness of a nutrition education program on the shopping and eating habits of people with chronic mental illness, was directed

at a specific program.

Many attempts at evaluation were undermined once again by methodological weaknesses. Denton (1982), for example, compared the effectiveness of three methods of teaching interpersonal skills to a chronic population. A small sample size and serious problems in their methods of selection precluded any meaningful outcomes. Stein and Smith (1989), using a pre- and post-education anxiety scale and subjective reports, did demonstrate positive results from a stress management program. Only seven participants completed the program, however, and there was no control group (rapid improvement would be expected with inpatients, often resulting from medications) or long-term follow-up. Despite these serious shortcomings in design, the authors concluded that stress management can be taught to depressed patients in a short-term structured group which incorporates cognitive-behavioral techniques. Stein and Smith are not alone in succumbing to the hubris of drawing definitive results from a formal research design. Griffin et al. (1985) measured the outcome of their stress management group based on participants' daily logs and a follow-up questionnaire one year later. The group was determined to be beneficial but the authors then overextended their conclusions by offering unjustified prescriptive recommendations related to such aspects as effective lengths of groups and amounts of skill practice time.

Not all evaluation results, however, were so supportive of the status quo in educationally-oriented groups. Millsteed et al. (1991) evaluated a group for women with eating disorders. Although positive change measured by quantitative measures was demonstrated, qualitative input displayed a clear rejection by the participants of the approaches employed. This led to a new configuration of the group. Goldstein, Gershaw and Sprafkin (1979) reported the effectiveness of Structured Learning Therapy on skill acquisition but not on skill transfer. Hayes, Halford and Varghese (1991) agreed with this latter concern. They compared the effects of a social skills training group to an activity group with people with schizophrenia. The social skills group was a highly structured group based on a behavioral base. The activity group facilitated social interaction through a task-oriented group which aimed to produce a tangible product or service (e.g., newsletter). There was demonstrated improvement in social skills following that group but this was not sustained in a naturalistic setting. Two of these authors (Hayes & Halford, 1993) later challenged the assumption of skill generalization. They reviewed the OT literature related to skills taught to adult psychiatric clients. Only 13 of the 77 reviewed even acknowledged issues of generalizabilty, and only four of these specifically assessed it. The authors did discuss at length strategies that could be implemented

into the educational approach to improve the chances of generalization.

Theoretical Base

All descriptions of educational programs retrieved in this part of the literature review supported themselves by identifying some theoretical base or rationale. As with the non-OT literature, this was usually in the form of defending the content or topic. A brief overview of groups addressing the area of stress illustrates this tendency. Research associated with the relationship between stress and schizophrenia pathophysiology supported Stein and Nikolic's education group (1989), Griffin et al. (1985) justified stress as a major factor in the etiology of many psychiatric conditions, and Stein and Smith (1989) provided an excellent rationale related to the concept of depression and the role stress is presumed to have in contributing to the illness.

There was often at minimum an acknowledgement of a theoretical framework. A behavioral approach is considered the dominant frame of reference used in psychiatry by occupational therapists (Hayes & Halford, 1993), although a cognitive influence seemed equally strong. An increasing number of educational procedures in psychiatric facilities were based upon principles of social learning theory (Lillie & Armstrong, 1982) which incorporates behavioral and cognitive approaches. There are numerous other examples of

this source of theoretical support (Grogan, 1991; Johnson, 1987; Stein & Smith, 1989; Taylor, 1988).

As with mental health education approaches outside of OT, a psychoeducational model is popular (Crist, 1986). Lillie and Armstrong's (1982) articulation of the psychoeducational approach to psychiatric care strongly influenced the profession. Their program was characterized as a "learning place, not a get well place" (p.440). Most approaches to client education in mental health OT label themselves as psychoeducational (Martin, 1991; Greenberg et al., 1988; Griffin et al., 1985; Stern, 1991a), but the conceptualization differs slightly from that in the general mental health literature. It is seen as an alternative to the medical model (Crist, 1986), and some go as far as to see psychoeducation as similar to adult education or to a self-help workshop (Neville-Jan et al., 1991). Use of the educational labels (ie. student, teacher, classes) distinguishes many psychoeducational programs. Stern (1991a) describes psychoeducation as being based on social learning theory. The basic assumption, however, that skill deficits are primarily a result of insufficient opportunities for appropriate learning and that the learning process will help acquire needs skills for living, is the same.

Educational theory rarely appeared on its own as a basis for approaches. This is surprising as even in the

1950s and 1960s there were vocal calls to incorporate learning theory into the OT body of knowledge (Smith & Tempone, 1968). When educational theory does appear, it is usually in the context of explaining a target behaviour. Taylor (1988), for example, drew on learning theories to explain anger but not to support her teaching methods.

There are other models or theoretical frameworks that support OT educationally-oriented groups in mental health. A model identified as part of the psychoeducation umbrella is Structured Learning Therapy. It was developed by Goldstein et al. (1979) from attempts to resolve the failure of most psychotherapies with lower social class clients. Research had identified social class linked learning styles based on differences in child-rearing practices. For example, middle-class families' emphasis on feelings and self-regulation provided good training for insight-oriented therapies whereas the lower class emphasis was identified as being on compliance with authority and action. Their model provided a specific format to guide patients through taped vignettes of concrete behavioral steps. Modelling, role playing, and social reinforcement appear to form the basis for learning. Structured learning therapy consists of 37 tapes that cover a number of content areas, the emphasis is on conversational skills. Further application tapes aid in applying basic skills to real life situations. Modified applications of structured learning therapy are described in

the OT literature (Nickel, 1988; Wallach, 1988).

The Psychiatric Rehabilitation Approach is another model applied to OT client education (Heras Dion & Walsh, 1993). The model was developed by Anthony and associates at Boston University's Centre for Psychiatric Rehabilitation and is commonly applied in long-term psychiatric care. This approach draws from several disciplines and is grounded in the basic belief that people need skills and supports in order to function in their living, learning, working and social environments. Much of the skill teaching influence is from behavioral psychology but client choice and involvement are highly valued.

A specific OT model which guides some education is the Model of Human Occupation (Gusich & Silverman, 1991; Heras et al., 1993; Kaplan, 1986; Rotert, 1993), developed by Kielhofner and associates (Kielhofner, 1985). It is a conceptual model for OT practice that divides individuals into three subsystems which address motivation, roles and habits, and skill performance. The influence and demands of the environment are also considered.

Some group programs successfully combined models. Neville-Jan et al. (1991), for example, supported their education for people with co-dependency personality disorder based on a review of literature related to physical and sexual abuse, and alcoholism. A psychoeducational approach structured the program and the model of human occupation

determined the content by conceptualizing areas of dysfunction. Brown and Carmichael (1992), in their assertiveness training, supported the program's focus through the model of human occupation and the instructional methods through social learning theory.

Since most approaches to teaching do so in groups, and because of the prevalence of group therapy in mental health practice, it is surprising that group theory is not routinely incorporated into the theoretical support of programs.

Summary

The practice of educationally-oriented groups in mental health OT practice shares many of the characteristics of the other areas previously discussed. A combination of didactic and experiential methods were predominant but a much stronger emphasis on life skills development as the aim of the educational group was noted. Although there was attention to outcomes of the education, critical analysis of the results was lacking. Cognitive and behavioral approaches guided much practice but there were also many thoughtful applications of relevant models. Once again, however, educational theory rarely guided approaches.

Summary of the Literature Review

This review of the educationally-oriented health care literature has narrowed from a broad overview of education in health care practice in general to the more focused areas of mental health and of OT practice. The review was completed with a detailed examination of literature specific to OT educational groups in mental health. Common to all areas of health care, but especially characteristic in OT educational approaches in mental health, was the structured group format with a pre-set curriculum covering life skills topics through a combination of didactic and experiential approaches. Throughout the health care literature there was a wide variation in the amount of attention to evaluating outcomes of educational intervention and to the theoretical base of the intervention itself. The OT literature, however, did tend to at least to be cognizant of these issues. Theory and general rationale, for the most part, focused on the content of the educational intervention. Rarely was there serious consideration of methods of facilitating the learning process. It is perplexing that OT, and health care to a large extent, despite embracing educational approaches, has not incorporated theory from education's expansive theory base. It is also surprising that the client-centred concept was never explicitly encountered throughout this entire body of literature.

CHAPTER FOUR: METHODOLOGY

Introduction

This study explores the experience of an occupational therapy group in a mental health setting. Chapter four chronologically describes the research process from selection of the group, to data collection and recording procedures, through to the analysis methods. Relevant ethical concerns and issues of quality are incorporated into the discussion.

Such a retracing of my thought processes and actions as researcher serves several purposes. The background information it provides is important to aid in the reader's interpretation of the findings and addresses the issue of transferability or generalizability in that it enables others to extend this work (Bogden & Biklen, 1992). This documentation also addresses, in part, the critical issue of trustworthiness by ensuring auditability of the research process (Guba, 1981; Krefting, 1989a; Morse, 1991a). This is especially important because of the risks inherent through my inexperience as a researcher (this is my first formal study) and even as a consumer of qualitative research. First, however, it is essential to discuss the nature of this study's inquiry so that it may be positioned according to its appropriate epistemological stance.

The Nature of Inquiry

Different interests or purposes of seeking knowledge require different methods of inquiry to reach different forms of knowledge. Jurgen Habermas, a philosopher, sociologist, and noted critical theorist, has made important contributions to our current understandings of these differences. A summary of some of the relevant aspects of Habermas's ideas will be presented. Unless otherwise indicated, I have relied on selected sources from the educational literature (Carr & Kemmis, 1986; Ewert, 1991; Kincheloe, 1991; and Mezirow, 1985, 1991) as conduits of Habermas's ideas. Despite some limitations of this approach, it serves well to portray Habermas as a heuristic device to describe this study's position on an epistemological framework.

Habermas suggests that our quest for knowledge stems from three areas of interests. Technical interests derive from our need to control our environment to satisfy such requirements as food and shelter. The second area, practical interests, satisfy mutual interests and needs and are primarily reflected in our use of language. Emancipatory interests stem from our drive to grow and to develop.

Diverse approaches to acquiring knowledge related to each of these interests or purposes is required. The

natural sciences (also known as empirical-analytical), based in the philosophy of positivism, can produce technically useful knowledge. The focus is on manipulation and control of the environment, prediction about observable events, and the generation of technical rules. Interpretive sciences (or hermeneutic), however, are the appropriate scientific methodologies for generating practical knowledge. Rooted in a phenomenological philosophy, this methodology involves inquiry with the objective of understanding meaning. The philosophical position underlying the third area, emancipatory interests, is critical theory. Critical theory encompasses two components. Enlightenment (i.e., understanding) happens through a process of self-reflection that, ideally, reveals the distorted knowledge that is preventing achievement of our true potential. Emancipation (i.e., action or praxis) completes the process.

Essentially, the natural and interpretive sciences aim to understand the world as it is (albeit for different purposes and through different means); critical theory tries to understand why the social world is the way it is and, through that process of critique, strives to know how it should be and acts on this knowledge.

Arguments to determine the "best" approach abound, most visibly in the quanitative (natural sciences) versus qualitative (interpretive and critical sciences) debate of research methods (e.g., Kielhofner, 1982a, 1982b; Yerxa,

1991). Each scientific method is a rational and valid process for knowing within its own discrete domain. It is being recognized that methodologies have no inherent moral qualities (Short-DeGraff & Fisher, 1993; Ottenbacher, 1992). A major criticism of the natural sciences, however, is that in having become the pervasive ideology, they have been used as a criterion for all forms and realms of knowledge. Deductive explanations of facts and causes are not the only valid form of knowledge.

Interpretive approaches are also widely criticised. They are dependent on the subjective understandings of the individuals involved, but these understandings may be the result of what Habermas labels distorted social and self-knowledge. Understandings are challenged, therefore, as potentially being meaningful but false or limited.

Occupational therapy is only recently breaking free of the exclusive grip of the natural sciences. This shift is reflective of the rise of postmodernism (Bogden & Biklen, 1992; Lather, 1986b) and, perhaps, also reflective of the profession's rediscovery of its roots (Serrett, 1985b). Positivism's domination in OT was prolonged. As recently as the 1970s, it was considered a sign of progress that published literature was shifting from descriptive approaches to quasi-experimental designs (Short-DeGraff & Fisher, 1993). Even in relatively recent research texts for the profession (Royeen, 1988), the emphasis is clearly on

quantitative approaches. For over a decade, the use of qualitative research has been advocated in OT as the profession has been moving toward a phenomenological philosophy. Its special relevance to OT and the frequent inappropriateness of quantitative methods and a positivistic philosophy are increasingly being recognized (Kielhofner, 1982a, 1982b; Spencer, Krefting & Mattingly, 1993; Yerxa, 1991). Qualititative studies began to be reported in the literature of the early 1980s (Kielhofner, 1981; Rogers & Masagatani, 1982). It is only recently that they have become not only common (Clark, 1993; Fleming, 1991; Griswold, 1994; Hasselkus & Dickie, 1990; Hinojosa, 1990; Krefting, 1989b; Schwartzberg, 1994; Vergeer & MacRae, 1993), but are even the focus of entire issues of such professional journals as the Occupational Therapy Journal of Research (e.g., 1994, volume 14, number 2) and the American Journal of Occupational Therapy (e.g., 1994, volume 48, number 4).

This study primarily aims to understand the group experience through the perspectives of the OT leader and some of its members. As such it is firmly based in the interpretive sciences. But as declared by Carr and Kemmis (1986), the aims of explanation (i.e., natural sciences) or understanding (interpretive sciences) are "merely moments in the transformative process, rather than sufficient ends in themselves" (p.130). In this light I attempted to move

slightly beyond mere understanding toward critique as I explored the extent to which the group experience seems to reflect a client-centred practice. The methods and immediate interests are interpretive: the guiding spirit emancipatory. It will become clear that pragmatic limitations did result in a study "on or about" and not "in and for" this OT group. I did, however, strive to adhere to Lather's appeal to researchers to "practice in their empirical endeavors what they preach in their theoretical formulations" (1986b, p.258) by aiming toward a research approach consistent with the study's client-centred frame of reference.

Research Methods

Entry, Selection, and Consent

The retracing of my steps as researcher commences with the preliminary stages. The process of selecting the research site, gaining entry, selecting the group and key informants and obtaining consent will be described.

It has been noted that "picking a focus, be it ... a particular group, or some other aspect, is always an artificial act for you break off a piece of the world that is normally integrated" (Bogdan & Biklen, 1992, p.63). Although this extraction is unavoidable in keeping the

research manageable, I did want to minimize the effects by selecting a single group as a naturally existing unit to be the focus. Initial decisions in the selection process were made primarily because of geographic considerations. All programs or institutions offering OT services up to a two and a half hour drive from my home were contacted to determine their potential for involvement. Only one facility, a provincial psychiatric hospital, met the screening criteria of offering mental health OT services that include groups and an interest and willingness expressed by the department head to be involved. Over a seven-month period, and a frustrating journey through the institution's formal (and informal) ethics channels, permission to conduct my research was granted.

The process of selecting the group occurred through consultation with all members of the OT department. I explained the nature and purposes of the study, outlined tentative methods and the implications to all who would participate and, through the ensuing dialogue, we identified the two most appropriate groups (one inpatient, the other outpatient) and an number of "back-ups." Many criteria were considered. The group needed to have an explicit or implicit educational aim, and several members who could potentially participant as key informants (i.e., adequately articulate in English, able to consent, available for the data collection and analysis period, and able to be

reflective). The degree of psychiatric symptomatology currently being experienced and the possibility of involvement in the study having negative effects, and finally, legal issues (i.e., Mental Health Act or forensic issues) were all considered. Therapists also discussed which groups would most benefit from this kind of involvement. The emphasis in the decision, however, was on the willingness and ability of the therapist leader to participate, and that therapist's assessment of the willingness and ability of group members to be involved.

At this point, time commitments of one group's leader would have meant a lengthy postponement of data collection, so the selection process narrowed to the outpatient group.

The therapist who lead this group raised the possibility of involvement in research to the group to determine their potential interest but did not give specific details. The possibility was also discussed with her co-leader. Permission was asked on my behalf to attend a session to provide a full explanation. We aimed to keep the therapist as separate as possible from the study to minimize any sense of therapist alliance with the project. We did not want her to appear to be endorsing the project. Later conversations, nevertheless, did indicate that for at least two of the participants, this was their perception.

I then attended the first part of a group session to explain the study and to ask for consent. I described who I

was and my purposes and I provided an overview of the study. This verbal explanation was reinforced with a written description. This letter of information addressed the nature of the research, its purpose and processes, what would be expected of participants, confidentiality assurances, opportunities for feedback, and so forth. At the request of a member, I read through this information aloud. Slightly different versions were provided to the therapist and to the members with more attention to the use of everyday language in the member's copy. These letters of information are included in Appendices C and D. I was clear that no decisions had been made and that all of this information applied only if they chose to participate. Much of this was tentative because of the emergent nature of the study. It was impossible to provided definitive statements, for example, of the length of time required for data collection. I did, however, provide assurances that participants would be kept fully informed throughout and stressed that participants would be free to withdraw at any time. Several members asked questions and some offered verbal consent as a part of this discussion. I left the room after all questions had been addressed so that people could sign (or not sign) the consent forms in my absence.

Two levels of consent were sought. First of all, I required consent from all group members and both leaders to have their group observed and, secondly, I required several

people to consent to participate as a key informants. All group members present provided consent for me to observe the group, and five of these seven people expressed interest in further involvement as key informants.

Because of time and resource limitations, I had decided to focus on the experiences of the OT leader and only three group members. I discussed the further details (also in written form) with those interested either in person and over the phone. This included the anticipated timing, expectations related to data collection, my view of this relationship as a partnership, involvement in the analysis process, confidentiality issues and, of course, their option to withdraw at any time. A corresponding letter of information was provided or mailed (Appendix E) and all gave verbal consent.

I then consulted with the group leader and together with impressions from my encounters with the people, decided who would best serve the needs of the study. I aimed for a potential diversity of perspectives, and considered their availability for the time I anticipated it would take to collect and analyze the data and the relative stability in terms of their psychiatric illnesses. Four of the five were selected to allow for the possiblity of one person withdrawing or being unable to follow through. The person not asked to participate was the most recent group member (he had only attended a few sessions) and seemed to be the

least able of all the candidates to maintain a focus in conversation and to reflect on his own experience. One client then withdrew from the study early in the data collection process because he had quit the group and was admitting himself to hospital.

Formal consent from the therapist was not sought until both levels of consent were obtained from participants. This was to minimize any sense of coercion. Group members may not have believed that they had a choice if the therapist has already agreed to involvement. At the time of our first conversation for data collection, I responded to any questions or concerns raised, provided a tentative schedule outlining the timing and commitments of the participants' involvement (Appendix F) and obtained signed consent (Appendix G). I considered this to be more of a ritual to satisfy ethics committees than any real assurance of ethics. Ethical issues remained.

The issues of "voluntary" and "informed" were my major ethical considerations in obtaining consent. These ethical concerns were addressed, at minimum, through the use of the forms with the participants' signatures providing evidence of informed consent. Throughout the research process, but especially while seeking consent, I endeavoured to share as much information as possible with the participants. I wanted to ensure that people were fully informed. I may have compromised clarity, however, by

providing too much information and by placing too much emphasis on the tentative nature of the information. It was obvious for at least one participant, that this "overload" resulted in limiting the person's ability to comprehend. Some of the questions participants asked well into their involvement clearly indicated that they were not clear of either my position as a student without affiliation to the clinic or of the study's purpose despite this having been explained verbally and in the written information package. I attempted to compensate by restating key points on each encounter, by being open to questions at all times, and by providing specific opportunities through the data collection process to clarify and addresed participants' concerns.

There was also the issue of how voluntarily members provided consent. Seeking consent in the group situation, for example, was the most practical option, but this may have resulted in peer pressure being a factor. I tried to minimize the effects of peer pressure in the relatively more important key informant consent by discussing involvement with interested members outside of group and by allowing a week's interval prior to requesting signed consent.

One of the issues discussed at length with the therapist and again with the group members was that of confidentiality and anonymity. Guarantees of complete anonymity were not possible. The therapist, for example, was a member of a small OT department and her involvement in

the study was known to all staff. Furthermore, the location of the study may be difficult to protect as there are few provincial psychiatric hospitals in the province of Ontario. Within the group as well, I could not guarantee that, for example, group participants would not reveal to others the names of the key informants. I was able to assure them that the content of what people shared with me during the research process would remain confidential, and I explained measures I would take to ensure this. This certainly was to be more of an issue in terms of disseminating findings; I explained that findings would not be presented without participant approval.

A final concern was to protect the participants from being exposed to any undue risk of harm. I was aware of several possibilities. Data collection methods, as will be described, offered minimal risk of harm. I did attempt to ensure that members' treatment would not be directly affected. Although I discussed this concern with the leader and was convinced that she was more than capable of keeping the boundaries distinct, I was especially cautious when talking with her. Quite naturally, we often slipped into collegial discussion (e.g., professional or clinical issues) and it required constant vigilance to refrain from disclosing my knowledge of the group members. I also chose to not enter the community of the clinic. My contacts were limited to those necessary to gain entry and collect data.

Neither leader was even aware with any certainty which members were key informants. During my observation of the group session, I attempted to be as unobtrusive as possible. In terms of the therapist, there was little chance of her involvement affecting her employment status as she was the acting director of her department.

Group Description

Through this selection and consent process, a group known as the Community Living Planning (CLP) group became the focus of this study. The CLP was one of a number of therapeutic groups operating at a community mental health clinic. It aimed to provide support and assistance related to community living through focusing on such skills as setting goals. The group had been operating for over eight years with an open format. New members entered as room permitted up to a maximum of 12 people. The group was co-lead by a nurse (who had been with the group since its inception) and an occupational therapist who divided her time between providing services to the psychiatric hospital and to its affiliated clinic. Group met weekly for approximately one and a half hours.

The official group description from the clinic's policy manual is included in Appendix C. A deeper understanding of

the group, as the study's aim, will be presented as findings in the subsequent two chapters. I will now outline the intervening measures between the selection of this group and the presentation of findings.

Data Collection and Recording Methods

In order to meet the study's aims I selected methods, within practical limitations (i.e., time and finances) that would best help me reach an understanding of the group experience. The focus needed to be on the perspectives of the therapist and clients. Many of these design decisions were made prior to entry to the field, but because of the importance of context and participant involvement, modifications did occur. The data collection methods employed encompassed three traditional qualitative approaches appropriate in interpretive research: observation, interview, and document review. My own personal experiences then added a further dimension to the data.

Participants and Researcher: Roles and Relationships

Prior to describing the data collection methods in further detail, the central feature of data collection needs to be acknowledged. As researcher, I became the primary data collection tool. This necessitated a transformation in

my view of self as clinician to that of researcher. Difficulties related to leaving behind the care-giver role and entering the researcher role (Krefting, 1989a) and to the contrasting goals of research versus counselling (Meara & Schmidt, 1991) have been identified. Although at times I did offer such therapeutic interventions as positive feedback, support, and, on the rare occasion, direct advice, I strove to eliminate these kinds of role distinctions. I merely attempted to respond as a person who had come into the relationship to learn from as well as learn about the participants. Having had no previous contact, and knowing that there would be no future contact with these people made this stance easier than I had anticipated.

I attempted, at every opportunity, to remind participants that they had inherent power in the relationship. Meeting times were scheduled at the participants' convenience, for example, but more significantly, participants determined what and how much they shared with me. Every participant on at least one occasion questioned if he/she was sharing what I wanted to hear. My response would be to remind them that I wanted to hear whatever they felt was important for me to hear in order that I might understand their experience of group.

Ideally, my relationship with participants would have been fully cooperative: a co-learning approach where knowledge is mutually constructed (Bogden & Biklen, 1992).

There were difficulties in creating this ideal. As I had anticipated, my relationship was closer to the ideal with the therapist participant (with whom I was on more "equal" footing) than with the group members (I carried the "elevated" status of both being an occupational therapist and researcher). Surprisingly, the more equal status I held with the therapist lead to other, unanticipated difficulties. I found I was able to listen and uncritically accept much of what members shared with me. In my interactions with the therapist, however, I found myself judging her against criteria of my vision of the "perfect" therapist. Despite these difficulties, most participants shared that they felt comfortable with me and, as our relationship progressed, stated that they trusted me. The main barrier, I believe, did not relate to the roles but to the very nature of this project. Fundamental decisions such as the aims and approaches of the study were made long before participants were even approached to be involved. A fully cooperative relationship was not possible.

The nature of the project also relates to a further ethical conern. Throughout the process, I was uncomfortably aware that the primary beneficiary to this research was me. It was through the involvement of these participants that I was able to work toward fulfilling the requirements for this thesis and ultimately, my degree. In order to truly respect the participants, some form of re-payment seemed necessary.

Participants were able, hopefully, to derive some benefit through their involvement. For the therapist, it may have been an opportunity for professional awareness and development. For all, it seemed to be therapeutic in terms of providing an opportunity to be listened to and to have personal views validated. The method of giving back data and analysis to the participants, as will be described, is usually considered only as a means of improving validity. I also viewed this as a way of returning something to the participants (Lather, 1986a). All data and findings as pertained to each person, were returned to the participants, and all four key informants were offered, and all accepted, a copy of the full thesis document. Giving back will also occur through negotiated means such as offering a presentation of findings to the group and to the OT department and clinic staff. Perhaps it will be these activities that occur beyond the bounds of the study that will move it toward more emancipatory ends.

Participating in the research likely also fulfilled further purposes for the individuals. One participant agreed to participate partly out of a sense of altruism, others may have agreed in order to alleviate the monotony of their daily lives, or to serve some secondary gains. One participant was open in ensuring that personal needs were met through participation. At one point during the data collection we had a frank discussion about how this person

would give me what I wanted (i.e., more impressions about group) if I then gave what this person wanted (i.e., to allow disclosure of some personal problems). This seemed to be a fair transaction.

Because I was the primary research instrument, the study's quality was closely connected to my competence as investigator (Brink, 1991; Field, 1991; Merriam, 1988). The qualities that lend themselves to being a "good" qualitative researcher have been identified (Lipson, 1991; Merriam, 1988; Morse, 1991a): creativity and a tolerance for ambiguity; sensitivity to context, variables, overt/covert agendas; a keen sense of timing; sensitivity in "reading" the data; and communication skills such as empathy, establishing rapport, questioning and listening, and ability to foster trust. Many of these correspond with the skills of a "good" clinician (Lipson, 1991). I attempted to remain aware of these personal and professional attributes and to build on them through ongoing reflection in order to maximize my abilites as researcher.

It was on this basis of roles and relationships that the data collection methods were undertaken. Conversational interviews, observation, document review and other supplementary interviews, as well as my fieldnotes corresponding to each of these sources of data will now be described.

Conversational Interviews

Conversational interviews with participants formed the dominant data collection strategy. Through these conversations I gathered data in the words of the therapist and the three group members so that I could begin to understand their interpretation of the group experience.

The conversations were a natural, unfolding dialogue between me and the participants. The labels in the literature for this type of interviewing vary and include unstructured, open-ended, nondirective, flexibly structured and informed conversational interview (Bogden & Biklen, 1992; Patton, 1990). This format best enabled me to work toward my aim of understanding participants' perspectives based on the assumption that they would be able to communicate their perspectives to me. It also ensured that there was no pressure to disclose anything with which they were not comfortable. Other than an opening question or aim of the conversation (included in Appendix H), prearranged questions were not constructed. Participants were allowed to talk freely from their own frame of reference. I attempted to use probes with caution. Usually I directed questions toward the issues that the participant initiated to ask for clarification or to encourage more specificity. There were times, however, that I did redirect participants back to issues more immediate to the group experience, and even found myself guilty of employing questioning techniques

on occasion that suggested responses to the participants. Most of my previous interviewing experience had been in the semi-structured to the highly structured realm, and I required constant vigilance to refrain from being more directive.

I had anticipated that it might be disconcerting to the participants, all of whom had experience with highly structured and directive clinical interviews (either as interviewer in the case of the therapist or interviewee for the members), to participate in such a different form of interview. I emphasized the conversational nature when discussing interviews. I avoided referring to them as an interview (i.e., we would be getting together to talk rather than for an interview) and described the expectations when obtaining consent. I also began each interview by reminding the participants that they were in control. I used such phrases as that they were my teacher: I the student (Krefting, 1989a). This did not seem to be a difficulty for members, however. Two of the members did share that they were nervous or uncomfortable initially in talking with me but rarely did any of the participants require encouragement.

I had hoped to locate the interviews in the participants' own environments, but left the decision to each participant based on where it would be most convenient and comfortable for him/her. Members chose a staff office

in the clinic, a home, and a favorite restaurant, and the therapist chose her office at the hospital.

I had decided on sequential interviews, an adaptation of Seidman's model (1991), to facilitate collaboration and a deeper probing of issues (Lather, 1986a), to aid in developing a trusting relationship, and to minimize the potential of the participants and me becoming overwhelmed.

The first interview aimed to focus on the historical aspects. I hoped to learn how the therapist and clients came to be involved in this group. I expected to gain an understanding of the personal and the institutional circumstances related to the existence of the group and the involvement of these particular individuals. Although widely varying themes were covered in the conversation, the major focus for members was on their personal problems and the processes leading to their referral to the clinic and ultimately, to group. The therapist covered, among other issues, the historical context of the group's development and her involvement as leader, perceived needs of the clients, her relationship with the co-leader and clinical decisions related to the group. Because my contact with the group members was minimal prior to this conversation, my purpose was also to begin to establish a relationship. More so than in subsequent conversations, I engaged in small talk. It is interesting to note that much less "off topic" conversation occured in those interviews located at the

clinic.

The second conversations were scheduled within two days of my observation of the group so that the experience would be fresh in all our minds. As with all conversations, the participants decided on the day, time and location. The intent of this interview was to concentrate on the details of the personal experiences of this group: what it is like to be in and live through this group. This session also provided an opportunity for me to check out my own perceptions of the group.

The purpose of the third and final conversation was to work toward making sense or meaning of the group experiences. This interview was intended to be highly reflective, although the degree of reflectivity did vary greatly between participants. This third conversation was not held with the therapist. Scheduling conflicts arose and because the aim of the third conversation seemed to have been addressed with her in the earlier two sessions, we decided to forgo this part.

I had prepared participants to expect each conversation to be one to two hours in length. The briefest was just over an hour, the lengthiest in excess of four hours.

Reliability of the informants can be an issue when interviews are the primary data collection strategy (Brink, 1991). Through the conversations, most participants returned to similar themes on several occasions. Some

inconsistencies were noted, but as will be addressed in the findings, this seemed to be something other than an issue of trustworthiness.

The most serious threat to the credibility of this aspect of data collection, I believe, were my behaviours as researcher. In reviewing transcripts and reflecting on the conversations, I recognized instances in which I was controlling the conversation more than I had intended. At times, this was in response to a direct request from the participant, but in each conversation, there were a few occasions where a shift of topic was initiated by me.

All conversations were audio-taped. I ensured that the equipment was in proper working order and was prepared with spare batteries and tapes whenever entering the field. Early in the process, I periodically checked the recorder's functioning during the interview. There was one instance that I lost approximately 15 minutes of conversation through carelessness. Tapes were carefully labelled and cross-referenced with the transcripts to facilitate reviewing selected areas at a later time if needed. A total of 12 conversations occured, and, of these, one was of poor quality with frequent and at times lengthy inaudible areas. In most tapes, only occasional words were inaudible, and some tapes were completely audible. I listened to inaudible areas a minimum of five times before marking them as such, and in those situations, I usually was able to recall the

nature of what was said. Transcripts were recorded on a word processing program because of its speed and ease in transferring data to the analysis program. Because of time constraints, some transcriptions were carried out up to two weeks after the conversation, and, in those cases, the meanings of inaudible portions as well as some subtleties in the conversation were lost. Within the transcripts, I attempted to document all verbal behaviour (i.e., unusual tone or volume, pauses, etc.) and significant non-verbal behaviour, as well as the spoken word. Transcripts were returned to participants after the second and the third conversations in order to check for accuracy and comprehensiveness, and to provide an opportunity for further reflection. This resulted in the correction of typographical errors and half the participants added further comments to clarify and extend meanings. I had briefly discussed this process with participants and reinforced the purpose through a cover letter enclosed with both sets of transcripts (Appendices I and J). All verified the accuracy of the transcripts. For some people, the strangeness of reading one's own words seemed to prohibit any ability to reflect on the content. "Do I really talk like that?" was a common comment.

The question of when to finish data collection can be an issue in qualitative research and was most an issue in this study in relation to the conversations. Because of

time and resource constraints, I was restricted in going beyond the three-session format. On the occasions when more than one interview was scheduled on the same day, I worried that I may have been rushing participants to closure as the time of the next appointment neared. Later analysis, however, did show that each session typically ended with little new information shared or with accounts very distant from the group experience. In the third session, which was intended to be reflective, most of what was discussed had already been covered in earlier conversations. The difference was that these same issues were often shared at a deeper or riskier level. A clearly defined research goal is suggested to aide in determining the point of data saturation (Bogden & Biklen, 1992; Miles & Huberman, 1994), but this study's goal of understanding could never be completely achieved. The group changes, the people change, and thus, the experiences change. I was satisfied, however, that for the purpose of understanding the group experience at that point in time, I had reached diminishing returns in terms of new learning.

Observation

Observation, as a method, occurred throughout my time in the field, and was recorded through fieldnotes. Each on-site visit, from the preliminary meeting as part of the process of gaining entry, through to the consent visit,

observation, and conversations, I remained attuned to these natural opportunities to gather information.

Formal observation of a single group session occurred between the first and second of the scheduled conversations. My participation, beyond reiterating my purpose and obtaining consent from two members who were not in attendance on my earlier visit, was limited to non-verbally communicating my interest. I attempted to be as unobtrusive as possible, and, in subsequent conversations, participating members informed me that my presence had not noticeably altered the group. One of the three members participating did not attend this session (nor has she attended group since that time). The therapist did wonder if her co-leader's behaviour had changed because of my presence.

Because this study aimed to understand the therapist and client perspectives of the experience of group, I saw my observation as providing data that was both supplementary and complementary to that from the conversations. It served to provide clues to people's knowing-in-action and theory-in-use (Schon, 1987), areas difficult to articulate, that I was able to pursue in subsequent conversations. I was able to clarify motives for behaviours I observed. Observation also enabled methodological decisions related to the worth of further observation sessions and additional sources of information. Most importantly, this observation provided a

context for further data collection and for the analysis.

Bogden and Biklen (1992) emphasized the point of context well: "To divorce the act, word, or gesture from its context is, for the qualitative researcher, to lose sight of significance" (p.30). The client and therapist perspectives, to be meaningful or significant, needed to be placed within their larger context. This observation session seemed warranted, but I believe it did create an unforeseen barrier to my understanding. Having seen the group, it was difficult to not feel that I now "knew" it. I questioned if I would have been more open and sensitive to participants' experiences if not biased by my own knowing. This confirmed my initial decision to limit observation to a single session.

Document Review

Review of relevant documents was an additional data collection strategy, as with the observation, that provided contextual information. The clinic policy manual (clinic philosophy, policies and procedures, discipline descriptions, treatment modalities etc.), medical charts of most group members, and some of the leaders' notes that they had brought in to previous groups were reviewed. I searched for information about official power and internal rules and regulations, clues regarding leadership style and organizational values as well as an understanding of the

official perspectives on programs. The medical charts gave some background information on participants, but primarily provided information about the perspectives of the documenting therapist and the assumptions inherent in the clinic's functions.

Copies of relevant sections of non-confidential documents were made, and notes regarding other information were audio-recorded and later transcribed.

Other Conversations

During my time in the field, informal conversations were held with other staff at the clinic such as the secretary/receptionist and the head psychiatrist. Once again, these helped to establish the context for my understanding of the group. The conversations with the group member who withdrew from the study were also considered for this purpose. Early in the process, however, it was apparent that the co-leader could provide valuable information, especially in terms of the group history. With her consent, an hour-long conversation was conducted in a manner more directive than was done with the study's key informants. This was taped but the co-leader did not wish to receive the transcript.

Fieldnotes

Fieldnotes have been defined as "the written account of

what the researcher hears, sees, experiences, and thinks in the course of collecting and reflecting on the data in a qualitative study" (Bogdan & Biklen, 1992, p.107). In this study, they served both as a method of recording data and collecting data that came from within me as the researcher (Bergum, 1991), and, as will be discussed, they served as part of the analysis process. The fieldnotes incorporated three components: objectively-oriented and subjectively-oriented notes, and a separate log.

The log section was used to document all contacts, schedules, phone numbers, and other relevant information for my reference. It also served as a record of decisions and rationale related to methodology so as to establish an audit trail (Guba, 1981; Krefting, 1989a). Within all notes, I attempted to provide precise and detailed accounts of all that I experienced related to the research process.

The descriptive or objectively-oriented portion of the fieldnotes was intended to record the data from my observational sessions and document review, as well as supplement the data I collected through the conversations. These descriptions aimed to capture a "word-picture" of the setting, people, actions, and conversations as I experienced them. It encompassed portraits of the participants, reconstruction of any conversation that occured "off-tape" (e.g., before and after the recorder was turned on, telephone conversations, etc.), descriptions of the physical

setting and the atmosphere, depictions of activities, and of my own behaviour.

The comments or more subjective portion of my fieldnotes were aimed at guarding against the erroneous belief held by scientists "that as long as they are not conscious of any bias ..., they are neutral and objective, when in fact they are only unconscious" (Namenwirth quoted in Lather, 1986b, p.257). Lather pointed out that research is never neutral. In this section of my fieldnotes, I encouraged my non-neutrality to emerge.

As is strongly argued by Moustakas (1990) in his work on heuristic research, the self of the researcher is present throughout the research process and while understanding the phenomenon with increasing depth, the researcher also experiences growing self-awareness and self-knowledge. Although not a primary purpose in this research, the comments component of the fieldnotes also served as a personal journal to recognize my presence and personal changes through the research process. It helped me remain conscious of how I may have been affecting and affected by the data. The comments also served an additional function. There will always be certain assets and limitations in terms of the researcher being human. As much as possible, I attempted to document my awareness of these factors, for example, biases, fatigue, distraction through other commitments, as well as intuitive thoughts and emotional

reactions.

The distinction between the descriptive or objective section of the fieldnotes and my subjective comments became difficult to make. The two components originally were specified by clear labels identifying the nature of the entry. What I objectively described was filtered through my perception and all of my decisions about what to record and how to record it involved my judgement. My emphasis was on "getting it all down." At times the subjective/objective distinction aided by focusing my awareness on one aspect or the other, but at times recording flowed and I chose to not restrict the process through such labels.

Most fieldnotes were dictated as soon as possible following each of my encounters in the field then transcribed within a few days. Unlike the transcription of conversations, I freely edited and added to enrich the data.

Anonymity of participants was protected through the use of initials in place of names and I changed any identifying information at the point of transcribing. The original data (i.e., with identifying information) are kept in locked storage and will be destroyed.

Analysis Procedures

"Data analysis is the process of systematically searching and arranging the interview transcripts,

fieldnotes, and other materials that you accumulate to increase your own understanding of them and to enable you to present what you have discovered to others" (Bogdan & Biklen, 1992, p.153). Presenting this discussion of analysis as a separate section from data collection and recording is somewhat artificial. Collection and analysis occurred simultaneously, although the formal process was left to the completion of data collection. Bogdan and Biklen (1992) recommended that the beginning researcher use some of strategies of analysis-in-the-field but not engage in formal analysis until at least most of the data are gathered. I followed their advice, partially because the relatively short periods in the field did not allow for time beyond that required to keep up with the collection and recording tasks, and because it took most of my energy to merely do that well.

Some of the strategies that I employed in the ongoing process of analysis began even prior to data collection. For example, for the purpose of obtaining consent, I needed to describe my research project's intent in layperson's terms. This helped me be clear in my purposes, and helped keep a focus for analysis. Later, ongoing reflection especially during the lengthy commuting time to the site, reviews of notes prior to data collection visit, and transcribing, which further familiarized me with the data, served in analysis. Even the subjective portions of my

fieldnotes became a vital form of analysis as I attended to emerging insights and modified approaches to further data collection. My own experience, as already discussed, was an important source of analysis (Bergum, 1991).

Sorting and coding of data formed the central procedure of the formal analysis process. My approach to analysis was somewhat eclectic and intuitive. I was influenced most by discussions of thematic analysis (Krefting, 1989a) and the phenomenological method (Giorgi, 1985).

I commenced analysis by re-reading the transcripts, my fieldnotes, and photocopied documents to gain a sense of the whole experience. I then returned to the central components of the data (primarily the conversation transcripts) and noted "meaning units" each time I perceived a shift in topic. I developed categories to code each of these segments of the data. These codes varied from the concrete (e.g., length of participant's involvement in group) to the conceptual (e.g., themes of power) to the arbitrary (e.g., each mention of "time" in relation to group). Appendix K provides the coding scheme with definitions.

I entered these codes into a computer software program called the Ethnograph (Seidel & Clark, 1984) that was developed to aid in the analysis of text-based data. I established rules for coding, and regularily referred to these during the process. I also periodically performed abbreviated searches of codes to ensure that I had not

strayed from the original definition.

I then experimented with the codes and constructed charts and diagrams to illustrate possible relationships between codes and to promote insights (Miles & Huberman, 1994). I also drew from Moustakas' (1990) discussion of specific strategies to facilitate and deepen the analysis process such as engaging in self-dialogue, indwelling, focusing, and incubation through this process. I gave myself permission to listen to my intuition and to trust my knowing and found this a freeing, energizing experience. Through this process, I formulated an outline of the common group experience: pre-group, in group, and post-group details. I then organized codes into this three-part reporting structure. This paralleled the aims of the conversations (i.e., all codes that related to background issues followed by all codes immediate to the group experience, then codes related to reflections).

With aid of the Ethnograph, the next stage involved searching codes within each of these three sections. I marked ideas or themes that were either repeated or unique, that intuitively were compelling, or that had been indicated by the participant as important during conversations or later upon transcript review.

I then reconstructed these marked areas of text, using the exact words of the participants as possible, into stories within a larger vignette of a fictional group

session. These formed an essential description of the individual's experience of the group. Chapter five presents this essence of the group experience.

These stories were returned to the participants. Appendix M provides a sample explanatory letter included in this mailing. Each person received his or her own pre-group and post-group story as well as an amalgamation of the in-group experiences of all participants.

All participants confirmed that the presentation of their experience "felt right." The option of receiving a copy of the completed thesis document was raised and lead to discussions about confidentiality. I ensured that everyone was aware that all key participants (i.e., the occupational therapist leader and three group members) would have access to the full stories. One member, who decided to maintain her own name in the report, was satisfied and made no changes. Everyone else requested some changes and chose pseudonyms. One member made only minor revisions to more accurately reflect her motivation to attend group. The third member was uncomfortable with the possible implications of a few passages. We agreed on changes that were less likely to offend others. Many changes were made at the request of the therapist including some style revisions, substitutions of words that could be considered offensive to others, and a replacement of some specific examples with more generalized statements. Most of these

modifications did not significantly alter the original meaning nor did they seem to represent participants wanting to present their "ideal" selves.

I then shifted analysis to incorporate more of my perspectives as researcher. I continued to work with the data from the participants but I drew more directly from the supplemental or contextual data (i.e., data from other conversations, from document review and from fieldnote observations and reflections). I returned to the study's frame of reference and organized codes according to the themes identified within client-centred practice. In the process of searching the data, I usually scanned the context of retrieved sections to ensure that meaning was not being altered in extracting it from the text. From this process, a discussion of the aspects of the group experience consistent and inconsistent with a client-centred ideal emerged. These findings were not returned to the participants.

There were of course limitations in this as in any analysis process. Stern (1991b) cautioned the researcher working alone. I had expected dialogue with others to be a larger part of the analysis process. Reflection on data and findings did occur through mail correspondence and phone conversations with participants, but face-to-face encounters may have better facilitated such a dialogue. I did maintain regular communication with my advisor, but for much of the

modifications did not significantly alter the original meaning nor did they seem to represent participants wanting to present their "ideal" selves.

I then shifted analysis to incorporate more of my perspectives as researcher. I continued to work with the data from the participants but I drew more directly from the supplemental or contextual data (i.e., data from other conversations, from document review and from fieldnote observations and reflections). I returned to the study's frame of reference and organized codes according to the themes identified within client-centred practice. In the process of searching the data, I usually scanned the context of retrieved sections to ensure that meaning was not being altered in extracting it from the text. From this process, a discussion of the aspects of the group experience consistent and inconsistent with a client-centred ideal emerged. These findings were not returned to the participants.

There were of course limitations in this as in any analysis process. Stern (1991b) cautioned the researcher working alone. I had expected dialogue with others to be a larger part of the analysis process. Reflection on data and findings did occur through mail correspondence and phone conversations with participants, but face-to-face encounters may have better facilitated such a dialogue. I did maintain

regular communication with my advisor, but for much of the process, I worked in isolation.

Summary

This qualitative study, positioned within the interpretive sciences, focused on the experiences of a group run at a community mental health clinic. Three members and the occupational therapist leader consented to be the study's key participants. Varied methods of data collection were selected to best facilitate the process of understanding the group experience from these people's perspectives. A series of conversational interviews was central, but methods also included observation of a session, document review, additional conversations, and my fieldnotes. Some strategies of analysis were employed throughout the time in the field, but the main process followed data collection. From the data sorting and coding emerged a representation of the participants' experiences of group (to be presented in the following chapter) and a discussion of these experiences from my perspectives as based on the client-centred frame of reference (chapter seven).

CHAPTER FIVE: FINDINGS

The Participants' Experiences

The findings from this exploration of the experience of an OT group are presented in two chapters. This chapter presents the experience from the participants' perspectives. The stories of each of the study's four participants are set in a three part vignette that represents a typical group session. Chapter six will then follow by interpreting this experience from my perspective as researcher.

Coming to the Group

It's midweek. Just after lunch. For almost a dozen people living in this small city and its surrounding communities, group time nears. Some make their way to the non-descript brown brick building, unremarkable among the commercial storefronts downtown. The place is known to those whose lives it touches; and to those passersby who take note of the unassuming sign on the glass front door. It's a mental health clinic. Only the small "Province of Ontario" symbol hints at it's affiliation with its more ominous parent - the psychiatric hospital safely distanced on the municipal outskirts.

Clustered at the sidewalk bench opposite the entrance a

small gathering purposefully drag on their cigarettes before going into group. One of the group leaders is among them...

Lee's Story:

My name is Lee, I'm an OT. I guess you could say I've been forced upon this group -- and upon Norma, the other leader. Groups are always co-lead you see. Two disciplines, male and female when possible. Really it's not so bad, it's just different from the other groups I do down here at the clinic and up at the hospital.

Originally when we developed a series of groups here eight years ago, CLP was designed for those less experienced in groups. Norma's been one of its leaders since the beginning. It's an ongoing group. These folks are just kind of living out there with few supports. It's a bit of a lifeline almost for them.

We have a manual so staff here all have a copy of the group descriptions. But I'm not always sure when I have a patient, which group I will send them to. Some have been shipped to this group because they need long-term care. At intake, though, we do ask what the client expects from us and offer group if it seems right and if there's room. But if they look like they'll be a very long-term patient, we sometimes don't give them any other choice but to go to some form of group.

The patients in group are seriously ill. They really

need a lot in terms of self-esteem. They need some education. Really though, they just want and need an opportunity to talk, to get somebody else's opinion, somebody else's perspective.

I've been an OT 23 years and here at the hospital 15. Nine years to retirement. I've got a lot of experience to draw from. The Rehabilitation Department director was cutting her clinical load so I took over her half time assignment down here this past winter. After being primarily in management at the hospital for so long, I felt really inadequate at first. I was looking for cookbooks to guide me. I still find myself dragging papers along that I've prepared for group, but I don't need them as much as I used to.

I've also developed my claim to fame at the clinic. The hopeless are mine. Maybe I'm low man on the totem pole but at least there's a place for me here. And if they improve, I'm wonderful. Not that I'm the only one who knows how to treat the chronics, but even with these people, I can always see the hope. My philosophy with clients is that I try to get everybody to laugh at their situation, and play a little bit.

I'm the eternal optimist. But when I talk about what I do, and about group, I can sound like a real complainer. I don't mean it. I find them quite interesting. I feel like I could come off sounding like I'm the big group leader and

Norma's the bad guy. I really don't mean that. Maybe we could even work well together if I took the time and effort to discuss my feelings on how group should be run, the things she does, week to week planning, those kinds of things.

Lee exchanges a quick joke and a wink as she leaves the smokers and enters the clinic. Others are already inside gathered in the reception area waiting for the inner door to be opened from the lunch time lock-up. Lee obliges and heads down the hall to her office. The others turn toward the group room to take their seats...

John's Story:

My name is John, and I've got all kinds of problems all the way around. Home problems, with the wife you know, personal things, problems with compensation board and stuff like that. Things bother me - driving, being alone, crowds.

Before I got hurt and all that back in the late '70s, I was healthy, strong, worked all the time, provided. Well I did have those phobias. But I used to get through life pretty good. Now I go to bed early and I'm up early. I'm up and down during the night. I've got too much pain. The mornings are worse for me. I sit there for three hours, smoke, drink coffee, cigarette after cigarette. And I think. By one o'clock, I try to get out as much as I can.

I get into my pickup truck and go down to the restaurant there. I'll sit in the corner. It's good and quiet.

I've kind of been a loner for a while. I had lots of friends but they look down on you like you're a nobody. You lose friends. Sometimes I'll go out in my boat though. It's a heck of a way to be. You can't do things. It wears. I'm a lonely, desperate man.

Going out of my trucking business, that was the big cause of it. Not being able to work at forty-five years old is hard on you when you're used to working all your life. Everything went down the tubes because of my health. That's what brought me here.

I got pretty down and out, pretty depressed. I suffered it out myself. I think I should have been up at the hospital. The social people sent me to a psychologist. He couldn't help. He told me I was too bad - to go see a psychiatrist. My brother-in-law goes here and told me about it so I finally got my doctor to get me here. That was, let's see, back in 1990. I've been seeing the psychiatrist here. I was always taking medication for pain, then I had to take antidepression pills and stronger nerve pills you know.

I had an interview with a woman in there. They kind of analyze you and she puts you in a certain group. For two years I was in the socializing group, and when it finished, I went into this one. Lee called me, and I just told her,

sure, I can try it. She didn't discuss too much. I figured it would probably help but I didn't really know what I wanted to get out of it. Didn't know what it was about. Someday maybe things will click together. I'll meet some friends and maybe a woman who'll accept me as I am. If I could feel better I might even do some volunteer work.

Maybe I should also have somebody to see. Somebody that I could talk to. But they're so busy here. They can't do that. I keep a lot inside I guess. Maybe I'll be able to get some of it out in group today. I don't know if I should.

The cigarette butt drops to the paving stone and John rises with effort...

I don't walk right in there you know. I usually sit on this bench here or stand in the corner, have a cigarette, look around... I don't know if it's feeling guilty or ashamed, or what it is.

In the reception area sits a woman waiting for the other group members to go in...

Debbie's Story:

My name is Debbie and I was having, or I should say I have problems communicating. That's why I'm in this group.

Most of my life I've found it difficult to talk. I am very critical of myself. And I'm not comfortable with my illness. When I get sick, depressed that is, I just withdraw. I shouldn't have this kind of problem. I'm an R.N. you see. I have this weird concept that a nurse is supposed to be able to talk and not be bothered when around a lot of people, things like that. I've been working at a nursing home for eight years now.

It took me five years part-time to complete the R.N. program. I had started at another college years ago but quit after a year and a half. I finished last year. I had to work full time. No holidays because that's when I did my clinicals. I worked like a dog.

I felt I was getting worse and worse and worse. Like when all the other students were around, I just couldn't handle it. I'd kind of felt like running out. So I went to my advisor, partly out of desperation. I had never before gone to her. I told her that I couldn't stop crying and things like that and she got me to talk to my family doctor. I did. He didn't do anything. Just said you're a little depressed. So she sent me to the social worker. I kind of laughed because that person said, well, if you have mental problems we can't help you here. My advisor was pretty upset that they weren't doing anything so she called the social worker and told her to get me in here. It took a long time. I had never heard of this place.

It didn't bother me coming here. I knew I needed help. But when other people see you walking out of here, they give you a wierd look.

I saw Norma first. I guess they have a meeting to discuss what they can do for me. Norma called me after and said that I could go into therapy with her. I was in therapy for about a year when they thought I was ready to get into a group. They asked me if I wanted to come in this group or another group. I tried the other one. Wrong choice. I resisted coming into this one for a long time. I had a great fear of repeating the same bad experience as with the first group. It was Norma that convinced me to attend both groups. I trusted her a whole lot.

For a while I guess I thought I had to come. I didn't think it would help. I thought - nothing is going to help me. I wouldn't have even been able to state my objectives for coming here. I've always been a person who doesn't let anything out. I couldn't talk in front of others.

I've been in it almost a year now and I'm really not comfortable. But I have to do it if I want to get better. I really have to push myself to get here. Almost push my feet. Especially if the last week's group went badly.

Today, I've got something important to talk about in group. At work, this week, there was a lot of yelling. I just can't handle it. I've written it down on paper so that it doesn't sound real corny. I'm all ready.

Debbie rises from her seat in the clinic's waiting area and follows the others into the group room...

Maggie's Story:

My name is Maggie and as long as he stays away, my "ex" that is, I'm okay. First of all, I suffer from mental illness. Severe depression, off and on for quite a few years. I never thought it would happen to me.

I lived with him for five years, had three kids, then finally left him when I was pregnant for my sixteen-year-old. Then when his other marriage fell through, he came knocking back at my door. I thought I was strong enough, but next thing I'm pregnant for my five-year-old. Then he was back with her again. I only had Grade Eight education. I'm overweight. I thought who's going to hire me. My self-esteem was shot. Then I got that job cooking in a restaurant - it really helped.

I don't know why I still have feelings for him, he treats me like a doormat. I just ... I just can't say no. Now it's starting all over again because he's back in my life. I don't know how I could let him drive me down. I lost it. You can't get back to where you were.

I always had a fear of cancer. In the 1980s I developed hepatitis and went into a coma. When I came out of hospital, I still thought that I was dying and they just

weren't telling me. Like whenever I get severely depressed, I get this idea in my head that I'm dying. I can't sleep, can't eat, then I'm right back, usually hospitalized then. I get mood swings - one minute I'm okay, the next I'm flipping. Seems like I can't deal, can't cope with anything. They tried all kinds of antidepressants. After getting shock treatment, it just seemed like it went uphill from there then all it took was for him to come back in to my life. Down I went.

I'm a shy person. I get intimidated by people. I'm the type of person that likes pleasing people. I guess you could also say that I'm a dependent person. But I laugh a lot. Some people might think I'm crazy because I laugh a lot. I have friends, lots of friends. And I take pride in my home. It doesn't take much to make me happy. Not like a lot of other people that are just full of pity.

Usually when I have problems, I always run away. Pack up and leave. This time it's different. I went to my doctor and told him I didn't want to be on pills for the rest of my life. I'd had my name in at the counselling centre, and for that victims of abuse group that I had been in before. Long waiting lists and they only ran for so many weeks. He said, what do you think about the mental outpatient clinic. And I said well, I'll try anything.

Initially I had a consultation with Lee. I think she took down information from me. They called me back after

their meeting and she suggested that I go into that group. I said that I wanted a one-on-one, but she gave me the statistics on their waiting list so... I thought, well, I need something right away so I said I'd try the group. I've been there ever since. That was, oh geez, almost a year now. I want group to reassure me that I'm not the only one with problems, that I'm not crazy. And I want the group to teach me assertiveness so I can say no to him. I need that support. I need to be inspired, that little extra shove, incentive. I'm trying to get back what I had before. Maybe go back to school and take something to better myself. I want to go ahead.

People see me go in there, you know they're going to think I'm crazy - but I don't care anymore. I feel I need that group. Your mind gets sick the same as your body does. And I feel good going in there.

When I get up in the morning on group day, I'll say oh, I should go to group. Especially when I can't cope or when I get edgy. I'll phone around and try to get a ride. I don't always have bus fare to go to group because I'm on a fixed income. I used to have to get a sitter too. Now my daughter's in school afternoons. Either I can't get one or the other, that's my way out, like my excuse. I'm not really comfortable there, especially with the men there now. It's the same faces so that's not too bad. It's the fact of going downtown and running into my ex. I'm more or less

afraid.

I haven't been all summer but I'm doing fine because my medication is working great.

The Group Experience

Nearly a dozen chairs are arranged in an uneven circle. One by one they are occupied as members file into the room. A one-way glass, in the otherwise windowless room, dominates one side. Three pictures decorate the off white walls. Recessed fluorescent fixtures provide even light. A coffee maker is on a cart at the side of the room and a flipchart stand with paper leans against the opposite corner. At its base are stacked pillows. A bright orange handmade cart with some pamphlets on top sits at the edge of the circle...

Maggie: It's just a room you know, and the door's closed and the people, they're all friendly, and I like that.

Lee and Norma enter last, close the door, and choose their seats...

Lee: Norma and I meet for one minute in the hall on the way down to group. I'm always careful to sit opposite Norma, but she isn't. I don't like it to look like the two of us against them. I really think the arrangement

makes a difference.

One side of the circle has flattened out as people shift chairs slightly as they take their seat. Debbie has pulled hers noticeably back...

Lee: Of course, Debbie never moves. She always has that same chair with her arm on that cart.

Debbie: I always do that.

Lee: Norma usually charges for coffee and tea. I'm not comfortable with that. When she was away, the OT student and I didn't even serve tea. Nobody even noticed.

John: They usually have coffee; yesterday nobody made it.

The conversations cease. The room is silent. People note to themselves who is here ...

John: They're all good people here. Like that one fellah there - he seems to be a pretty good guy. Someone who could be a friend. They're people that have problems. I don't know what their problems really are. I think most of them have been into the Ontario hospital; where I haven't. Quite a few people have gone through a depression.

Lee: Most of them are pretty depressed and virtually would

stay home and vegetate all week. There is quite a span though. Those at the low functioning end might have the odd kind of problem - nothing earth-shattering. These people would be better having some place where they can come in and chat it up. They're beyond therapy. Others are higher functioning. We have these actively acute people with real live problems. One man in particular might be transferred up.

Maggie: That one fellow there, he really expresses himself. He seems like he could almost be a leader himself.

Debbie: I'm so quiet, other members don't really know me.

Maggie: Like I know them by their first names but that's it. People that are in there aren't out to hurt me. So I trust them that much you know. And the leaders are fantastic. Lee's humorous, she's witty and Norma's more serious.

John: Lee is the leader I guess, the head one. Norma's a nurse and she helps out.

Lee: Norma is sort of the support person. Where I try to be, I don't know whether I come across, as more of everybody's equal and friend.

John: Lee is sort of more aggressive where Norma is more sentimental.

Debbie: The leaders are both great.

Maggie: They're good together.

And people reflect on what group is about ...

John: They're so busy at this clinic that they can't do that one-on-one all the time. That's why they have the groups.

Lee: Originally, the idea of groups did come up because of cost efficiency. Group is meant to do several things for its members. They get some motivation to do things, it's a place to get some support, and gradually we're teaching them some skills.

Debbie: I have no idea what its official goals are. Norma explained to me that it's a lower functioning group and they don't push you. I was told that group was for people who have a hard time talking with others but it's not really. There's no way I'll ever talk like some of them talk the first time they're here.

John: It's to get together to try to discuss your problems. If you want to talk, you talk. No one forces. Then you hear other people's problems. Sometimes you get mixed up, you don't know what to do and that's what the group's all about. They try to set you straight.

Maggie: I think it's set up to help you cope with, you know, all the stresses of life... just to pave the way, to give you an incentive to carry on. They show you that you're somebody and that you've got a purpose in life. You can go on and be happy. Like we can talk on

anything we want and nobody's judgmental. It's not a forceful group. Sometimes it's just chit-chat time, we might do something like exchange recipes but there are pretty serious topics at times too. Then a lot of times it's fun.

Several vacant seats remain...

Lee: It is difficult to get some of these really chronic people to commit to coming in weekly. They want to come in when they want to come in. One pair of ladies, for example, usually alternate weeks.

John: There's another guy, I don't know, he's not going to be at group for a while. I don't know what happened to him. And one lady died.

Debbie: They told us this lady passed away but we didn't really talk about it. I couldn't pay attention in group for a couple of weeks after.

Maggie: I think I'm the one who's been there the least now.

Lee: Most though are very reliable and call up apologetically to say if they can't make it.

John: Sometimes I can't make it to group. You're in pain, depressed. And there's been times I've had company, or doctors' appointments. They say you don't have to explain why if you miss. I don't worry about it if I can't go.

Debbie: I never miss any sessions and times when it's been cancelled, I feel lost. There are others that just come once a month or something.

Lee: Some just get peeved every once and awhile. They're tired of being a sick person so they go away with our blessing and end up drifting back a couple of weeks later. Another problem comes up and they've got no support for it.

It's 1:20 p.m. ...

Debbie: It used to start right at one o'clock and people would just kind of straggle in. They changed it to quarter after. Usually everyone's there. But now it's starting up again.

Lee: We had a problem with the one o'clock start time. People were wandering in late and everyone was getting fed up. So we discussed time and the group voted on it. So the group is supposed to start at one-fifteen.

Maggie: Say someone wanted to leave early the leaders they always say, well it's up to the rest of the group.

John: That's the way this group is run. If somebody's got some suggestions or something, they ask the group about it. If that's all right.

Lee comments that they hadn't set goals lately. One

member begins to speak without further encouragement. The group session has begun ...

John: Usually everyone talks. Well there's one girl who doesn't say too much but she never does. And last time, one lady was going to sleep. Everyone takes their turn.

Debbie: At first I kind of felt like I was in a classroom in high school. We'd always had classes in a circle and took turns talking. This is not as bad.

Maggie: I never start off. I find it hard to start talking. I'll just sit and listen, wait my turn. I never plan on what I'm going to talk about. Sometimes I feel self-conscious, so sometimes I feel that maybe people are staring at me, but then the feeling goes away. As group goes on I get more comfortable.

Debbie: I don't feel good in group. At the beginning of every session, I don't feel that I belong. There's a lot of different emotions going through me. Everybody's going to be looking at me, and everybody's going to be listening to me, and I don't want to make a fool of myself. I want to leave. It's very difficult for me to stay in the chair. I have to hold on to the arms a lot of the time. Usually that works. A couple times I've gotten up and just walked towards the door and then thought, better not.

The spotlight is moved from one member to the next. People talk of their day-to-day lives - difficulties making decisions at work, worries about menstrual irregularities, a relationship that's leapt ahead with a marriage proposal, discouragement from being out of work, and even talk about not wanting to talk in group this week...

John: I usually talk in group. Sometimes I don't say too much for a couple of weeks but sometimes I really get going, really get wound up. Things like compensation board and stuff like that, well that's easy to get off your chest you know. But when it really gets personal, then it gets a little more difficult.

Debbie: I'm starting to talk a little more. But for awhile, it was only very superficial. Now it's getting a little more personal. With the previous leader I wasn't talking at all, but with Lee, something just clicked. There are certain things though that I won't talk about. Really personal things like if I was abused or something or things at work, like if I made a serious medication error.

Maggie: I've pretty near talked about everything. There's never been anything that I can't talk about. Well, there are probably still some things that I wouldn't talk about in front of the men.

John: Well I hold back too. I think a lot of people hold

back. I've heard a couple of people say that. Because it's personal and stuff like that. I got a lot of problems that I don't even say to them, not yet anyway. I feel really bad. It really bothers me but I don't say nothing to them.

Maggie If something has got me really down, then, sometimes I just go and sit there and sometimes even break down and cry.

John: I go home and break down. I don't want nobody to see me. I feel like if I ever broke down in group, like the other time, I'd never come back for months. I'd be really embarrassed. Yet it would bother me not going.

Lee: John did cry one day in group. Which was interesting, because he says he can't share some things because he can't cry.

John: Well, it's the people too, I guess. Some people talk about their problems and to me it's so simple. To me it's not a problem, but to them it is. To them, my problems might not seem to be a problem.

Debbie: It's almost like everyone keeps their own feelings and thoughts to themselves type of thing. But some people do get into personal things, yeah.

Occasionally group members shift from speaking to the leaders to interacting with each other. Usually this is orchestrated by the leaders...

Lee: There's a little bit happening in group but you have to make it happen. It's kind of our knowing their background and being able to pull them in to the conversation. Or picking up a little grin or a little smile or tear or whatever. And then moving on to the next person.

John: When they start questioning you about things, then it's a little harder because you don't know how to go about it sometimes, and you don't feel like talking about it. Sometimes its harder for me to answer Lee than it is Norma. Lee's been pretty good, she has a job to do, but I know Norma better. She lead the last group there. I'm more comfortable with her.

Lee: I'm pretty spontaneous in group. I've got a lot of experience, so I'm comfortable. I mainly offer ideas. Something they can select from. I also see my role in any group as a bit of a spy for the doctor. If a crisis is starting, I can alert him. I might introduce a topic based on what someone's shared. Like how can we remember better. And then I'll go back and say, do you think you'll be able to use some of that? I bring it back to the problem.

Maggie: The group leaders say things like - well do you like being treated like that? Well then, you're the only one that can change it.

Debbie: Even the leaders share a little bit about themselves

and you get a feeling that oh, they're human.

Lee: Sometimes Norma and I differ greatly. I think I'm probably more comfortable now cutting in and cutting her off and doing my agenda. Like when I'm picking up something that's sounding strange to me, and she's belittling it. Or she can go on and on and on about something that I had just said two seconds before. Or I might be trying desperately to move group into a discussion and Norma just cuts it off and moves to some airy-fairy discussion of something. Although Norma will recognize when she's put her foot in her mouth. She is good that way.

Debbie: It'll take me a while to answer often, but it's all in my head. Then sometimes I'll say something and I'll regret it after. If I go overboard I can feel awful for weeks after. I shouldn't have said that. That happens quite often. Then I won't talk for a few weeks. Especially something really personal. Like the time I took a chance and talked about the suicidal thoughts I was having. I guess I don't want to reveal a whole lot about myself. If somebody else is talking, I'll say that's what I've been doing. Like I disclose myself that way but I don't come right out and say something about myself.

John: Sometimes I have advise in my head, or I have an idea of something the group can do, but I don't say

anything. I'm there as a patient as anybody else - I'm not a leader. I don't want to be the one who has to take over the floor, to make the decisions. But I do like to help people out if I can.

Debbie: People will say or do something that you really don't feel that they should be. But I keep it all inside and don't say it. Or I get ticked off because someone's taking up all the time. I won't say anything though.

Maggie: When someone else says something, when there's a subject brought up that I can relate to, well then you know, I'll talk about it, then listen to advise. But I really see myself going there to get help. I don't know if people are picking up off of me.

John Sometimes they do more of a class.

Lee: When we do a concrete something, they're always excited about the new learning. Once in a while I'll even take out that board, that flipchart. It's amazing, like they remember the concrete learning skill lessons well. There's a lot of physically disabled people in our group, so one week I gave them conservation of energy stuff. We never got back to discussing it yet. I feel guilty. We were supposed to discuss it.

Debbie: I like the lectures, things like what we've done on anger, stress, back pain.

Lee: I wanted to do assertiveness so bad it isn't funny.

Basically I'd identify who's what and why would they be that way. That passive and aggressive people are both the same, both low self-esteem. And how simple it is to become assertive. I usually teach a script - something they can go ahead and use right away. Then over groups, we then use that to build. But something always seems to come up when I have this planned. So it's put aside.

Maggie: I don't like the exercises she has us to do. Like one day she had us listening to a relaxation tape and she wanted us to follow the instructions. I couldn't. I couldn't sit there in a dark room and close my eyes. I couldn't. Or sometimes we do role playing. I don't like that. I can't get into it.

Lee: Norma also often has some concrete exercise. She likes to do them too. One day she brought in this exercise. She just kind of flashed it in front of my eyes. She belabors points, so she went around and belabored the point of what are you feeling. And I'm thinking to myself, these people don't even know how to label feelings. And she sort of badgers them to come up with a feeling.

John: One day we had to discuss how we felt. Everybody had their turn. We had a paper with different sections. That makes it easier, having it on paper. Like you could read and could pick out the things you'd more or

less like to be like. It was interesting.

Lee: I also like to do my little cognitive therapy thing. The feel-think-do kind of thing. I try to make them take responsibility for the fact that this feeling isn't coming directly from the event. That they can change this feeling if they change how they think of this event. And they all remembered that. I've done this in depth when Norma is not around. It's not a formal thing who is the more active leader, but partly has to do with who holds the book. And who holds it depends as much on where the book was last left as anything. We use it to jot notes as reminders for ourselves. Things like people's goals.

There's been no formal exercise this session, but Lee reminded the group of techniques taught in previous sessions. Everyone's had a turn. Everyone's identified a goal for the week...

Debbie: We come in and they do the goals, unless like someone's in crisis or something.

John: They set goals. They want you to set a goal for that week, and see if you can get it done, you know. Some people complete them, some don't. So then they kind of want to know why you didn't complete your goals.

Lee: You should set your goals so you feel better about you.

But they still need the leader to say good job. Even some who I wouldn't have thought needed that type of structure really like that.

Debbie: That was one thing that really helped me from week to week. Setting goals helped me get a little bit better every week. And then they go on to something else. For a while they kind of changed it to the goals at the end. Now they changed it again.

Lee: I feel strongly that goals should be done at the end, so that presumably, you make a goal based on something happening in your life that you've discussed in group. They said then what happens is that group runs on at the end and they never get a chance to goal set. This is what they voted for. So they basically come in and most of them already know what their goal's going to be.

Debbie: And speaking of goals, it seems strange that some people will have a goal that is something physical, like I'm going to clean my stove this week. And then other people it will be something really philosophical. I want to say something like, these goals should be for yourself, to better yourself, type of thing. Anyway, usually they won't let you go without giving one.

John: We're usually out of there by three.

Debbie: Usually ends about quarter to three.

Lee: When we had that discussion about times, we ended up

splitting hairs. The group is supposed to go from one-fifteen till two thirty-five. A lot of people kind of pack up at two thirty. Debbie's usually the one to break the group.

Debbie: If I have to work on group day, I start at three o'clock. So I have to be out by twenty-to.

John: By the time we get out of there, holy god, everybody seems to be smoking after.

Leaving the Group

People file out of the room into the hall. Voices mingle. Some rush off to work. Another to get the bus home to be there when a child gets out of school. One takes a seat in the reception area to await an appointment with the psychiatrist. And another catches a group leader to follow up on something that couldn't be discussed in group. And some head out to a nearby restaurant for coffee together...

John's Story:

It was a good group today. Everybody had a chance. The group really helps me. It's been about half a year for me and I think without it I would have ended up in the psychiatric hospital. I expect to stay in group for quite awhile. It's important to me.

A lot of times you go in there and you're not feeling

that great, you come out feeling a little better. Other times it doesn't work that way. And at least it's something to look forward to, to get out. It gives you something to do that one day of the week. A place to go.

They don't force you to do nothing. They don't force you to say anything, talk, or nothing. They're good to you. But I don't like to be questioned personally. They do that sometimes. I don't want to say anything bad about them, but that one leader - I always forget her name - Lee, yeah. I've been hurt by things she's said to me in front of the others. Like when I was signing up for this study. I feel more comfortable with the other one. She's a real nice lady. When there's only one there group does change quite a bit.

If I go and listen to other people, it kind of helps. So that you know that you're not the only one with problems. Some have worse problems than me. Like being an alcoholic or something is worse than being depressed. And when other people say something, you figure, well, it's okay for me now to say what I would like to say. That's a great part of group therapy.

Another good thing is you can get things that bother you off your mind. It's a place you can go to spill out your beans. People understand you because they have problems. I have been disappointed or let down at times. Everybody has their times like that from my understanding.

Those times that you want to talk and you can't because you don't have the time.

The leaders and the people more or less talk to you and ease your mind. It's supportive. Not only the group leaders discuss it but the rest of the people will try to help you out too. They give you advice - how to cope with your problems. Like I was told through the group, which I didn't know before, to just take it day by day, step by step. Sometimes I put it to work. So that's part of my support. And if I can do something for somebody else, I feel like I accomplished something.

I think it would be nice if you could get out of that room and go somewhere, like for coffee. Maybe if it's a nice day go sit somewhere quiet in the fresh air. You're cramped up in that room all the time. A while back I suggested to the leaders, not in front of the people, that I could take people out in the boat to Lee's place for a picnic. They more or less leave it up to you to ask the group. Nothing was ever mentioned so I didn't say anything.

I'd also like to see more one-to-one. Even if you're in group, maybe you could talk to somebody by yourself.

What I'm trying to do is get some group members that can get away from the group and go out and associate. Like more or less get to know each other better. I do get together with people I've met there. We talk amongst ourselves. Sometimes it's easier for me to talk then. I've

even taken people out on my boat. One woman there, we went for coffee. I said maybe we can help each other. I don't know what she figured, that I was going to try out a relationship - it wasn't that at all.

My brother-in-law has started taking me down to the community centre. I've got to get a referral. They do all kinds of things - cards, dinners, they even go camping. It's a good place to meet people. I still take pills too. Sometimes Demerol, it gets me higher than a kite for pain. And I always carry my anxiety pills in my pocket in case something really bothers me. Sometimes I wonder if I should throw away the pills and start drinking again.

Group has helped though. But even the doctor said I probably won't get out of this rut. Once you get into a rut for so long, it's hard to get out of it.

Debbie's Story:

I find that this group has really helped me a lot. When I first started at group, I didn't think I'd be half as good, not good, but half as better as I am now. I never thought I could be like what I am now. Without group, I'd still be the recluse I was.

At first, the leaders would see changes but I didn't. Then suddenly I noticed about eight months ago. I joked about something at my parents' home and everybody just looked at me because I'd never done that before. That was

my first realization that something was different. At work now they see changes in me too.

I can give my viewpoint now, I couldn't before. I feel I can open up more with people and I'm getting a bit more personal in group so I guess I'm getting better. My fears aren't as strong. I find I know more about myself, I never really looked at myself before.

Oh, there has to be a lot more change yet though. I look at the progress I've made in one year, and based on what's left. I see myself being here another two years. It does go fast though and I do regress at times.

At first when there were only three others, I felt very accepted. Now that it's bigger and different types of people are here, that feeling's not so strong.

What's good though is that I can act the way I feel. Like if I'm having a bad day, it's alright. I can feel free to say exactly what I'm thinking. In other places, people are going to think, you're kind of off the wall. In that way I feel accepted in this group.

If I don't feel like talking about something, well then that's fine. They don't pressure. The leaders are great. Although now that I'm starting to talk, I'm getting a little bit more pushed. And if people are talking about themselves, then I'll be more at ease about saying something that I had done. It sort of gives me permission.

Knowing that there are people out there that are like

me helps. They're similar. I feel more like I'm at home because they're going through what I'm going through. Someone off the street, they don't really understand. Now I don't feel like I'm the only one who feels like this. There are other people. But in a way, I'm not like the others. I have a full-time job and there's different things about me. They don't identify with. Like being a nurse, it's almost as if I should be in the leader's chair not the patient chair. So I belong but I don't.

Just being here gives me that sense of belonging. You kind of look forward to being able to be here, let out some steam or whatever. You sort of get used to these afternoons, that's what you do. And just from listening, I can learn better how to talk to others.

I'm also learning about my coping. When other people are talking about things, they reveal things - well that's exactly what I do - type of thing. I realize why I'm doing things. And I learn how to deal with certain things, like, talking with and dealing with people. And of course the goals are good because they give me something to work towards. They really help me get a little bit better every week.

The lectures on a specific topics are good too but they don't always work out because people have lots to say. I would like it to be more organized though. Have a certain topic each week, so we have always got something you're

prepared for. And if there's something else going on, fine. Maybe part of the group the topic and part just for people's problems.

If I could there's other things I would change too. Like I wouldn't have the bright lights. And I'd only have three or four in the group like it was when I started. There's other things that bother me too. When I say something, I'll feel guilty after because I took so much time. Sometimes I'll regret it after. I guess I don't want to reveal a whole lot about myself. Or I'll say something and the next person will change the subject real quick or what I say will be overlooked, and then I'll feel like a real shit. For a while I thought that they didn't like me, or that what I said didn't really matter. Then I'd feel that I shouldn't be here.

At times I'm disappointed. Like if only one person gets most of the talking the whole group and you can't get anything in edgewise, and there's something that I want to talk about. I might have psyched myself up for two days and the next week I won't be ready any more. Certain people will monopolize the whole thing. When this happens, I'll be very critical of myself, 'cause I'll be really mad for not saying what I planned to say and then I'll think to myself, well, they shouldn't have been left to talk about such and such for whatever.

Now I have to head to work. They always schedule me

afternoons on these days so I don't have to miss group. Things from group usually kind of jump into my head as I drive along. I'll run myself into the ground for some of the things I said. The way I act in group has a big influence on the rest of my week.

I also see the psychiatrist here now and then, mainly for my medication. It took a long time but now I've got a med routine that works well. And I've also got counselling outside of group with Norma, every three weeks. What I'm doing with her is more what's happened before, whereas group is preparing me for the outside world. We don't usually discuss group unless there's something really bothering me.

Quite a while ago she did get me to sign a contract that I would stay so many months. I guess she knew from past experience that I always quit things. It was kind of a "you're going!". It's not like that now, I'm not being forced to go. I talk to the other leader outside of group a little too. I don't ever get together with other members though like some do.

I've put this group at a real high priority in my life right now. I have to change. For some of the others, it's not that important. For me, though, it's changed a lot of my life.

Maggie's Story:

I like the group, I really do. I find in these groups

you learn a lot, as well as get therapy.

I don't know if I'm better or not since starting group last year. I guess I am in a way, I've come a long way. Now I can sit and think. And my thoughts are different. At one time I'd never ever think about going to school and now I want to. I used to think I was crazy. I enjoy life now.

Nine times out of ten I feel really good when I come out of there. Instead of sitting in the house I can count on that one day, to spend two hours there. It's something to look forward to every week.

If something gets to me I can go and say it, at least you get it off your chest rather than let it eat away at you. I can say whatever's on my mind and I know that's where it's going to stay. Before all I had on my mind was my relationship or whatever.

And I feel like they understand too. Nobody knows what you're going through unless they've been through it. Group also reassures me that I'm not the only one with problems. Like I know there are a few people in there that are worse off than me.

Nobody's judgmental. They don't criticize you. They're not saying you're right; you're wrong. They just listen. Yet sometimes I'm afraid to say things for fear that, you know, they would think I'm stupid. I can feel what I want and not get criticised. I feel safe there too.

All the group members they try to give you advice, and

you can take it or leave it. They kind of guide you along. I don't know if I have anything to contribute.

I just need that moral support, that arm around the shoulder. And that's what they give you, they encourage you. I've seen great change in other people, and that's encouraging too. So you think if she can get from there to there, then you can get from where you are to...

In group I've learned that you can say no and it's not your fault if people take it the wrong way. I have the right to say no. And I've discovered that whatever feelings I had were mine, and it was alright. There's also a lot of fears I have and they help me deal with that. You see some things different, and that does help. But there's still something missing. Especially compared to when I was on one-to-one. Only one person can have the floor at a time here and in one-to-one you can just say whatever you want. I could talk more so it did more for me. It worked faster.

I'm not even sure what changes I'd make if I could, other than being an all women's group maybe. That's what I thought it was when I first started a year ago. Then all of a sudden these men started coming in. That really threw me. Like the first fellow, I thought he was in the wrong room.

But in the back of my mind I always say, well I have my group. At least it's there. If things get too bad, it'll be there. Before I had nothing. Group is something I can depend on. I plan on sticking with it.

Norma has also said to me if you ever need to talk, call in anytime. Like if I feel it can't wait until group. The doctor has also offered. I've got friends that help me too but I don't associate with anyone else in the group. I thought you're not supposed to. And my little one - she knows just the right time to give me a hug.

I'm glad I made it to group today. I feel better. It lifts my spirits or something. Now I've got to meet with the doctor to renew my meds. Since I've been on this latest one, I'm so much better. I'm not depressed now - I think it's really the meds. I have more energy now, I've cut down on my eating. I'm just starting to feel better all the way around. Maybe part of it is because of group, at least, I think group would have eventually done this.

Sometimes it seems like I'll never get back to where I was before. But I know eventually some day I'll be there. It will get easier and easier. It just takes time.

Lee's Story:

So that's my group. They really like the goal setting, even those people that I wouldn't have thought needed that type of structure. It's sort of like a "Weight Watchers" - set a goal, come back, see if you've accomplished it or if not, why, and set a new goal.

They're always excited about the new learning. Although I'm not sure how capable some are of taking it all

in. We spent at least 45 minutes in one group helping a person problem solve an issue and at the end, this person's comment was "Boy, I don't know what I'm going to do."

Some of these people, especially the originals, suddenly don't quite fit. It used to be more chronic and now it's taken a more upward role. They would be handled nicely in a social support group. Norma knows their backgrounds better than I so she caters to them whenever they want to talk. We're getting caught going backwards just in order to make them feel a part of the group. But it's easier to let them come and go as they please and they still feel they belong. It's their only social outing. How could we take it away?

When I picked this group up, I didn't think it was meeting its original criteria very well. So I've been trying to structure and teach more in it. Often though these attempts lack continuity. We don't follow up on what we've done. And when we do a concrete something, when we introduce the structure, I get a feeling that they leave without saying what they needed to say today. Without having gotten the support. I'd like to do it alternate weeks so that they have time every other week to learn a skill they need to apply to their situation. We started to do this but then somebody appears who hasn't been around for a while. And they're here because they have a problem. Another idea is to teach them skills outside of the regular

groups at the clinic. We could offer something like workshops, so that when we do it in group, it would be quicker and better.

But the clients do really benefit from being able to talk and get some new advise or perspective on their problem. A perfect group has members talking to each other but what's the harm in member to leader as long as everyone gets a little floor time and feels they can talk if they choose?

I think the true benefit of group is sharing what you've learned. You see a little sparkle in their eye when that happens. But generally, they're not very good at helping each other out. Some feel they can dish out their problems and then say, well, gotta go! There's been lots of new members this past four to six months so the group is fairly new right now. We have to work a little bit more on building basic group skills.

I think they're capable of moving at least to the next level of group - somewhat more interactive. Obviously they're fairly parallel at the moment. I think they're capable of a lot more and I think I could probably direct that. It's very difficult in any of the groups I've been in to get the clients to interact and be this high level group. And CLP is the lowest level group I lead. They tend to be passive and look to the leader for answers. And we're the identified leader figures.

We do also need to do more client evaluations to see what they want more or less of. We give them out to other groups but haven't done CLP yet since I've been in it. You get really interesting comments. And some surprises.

I'm more motivated to do this group than I thought I was provided that Norma and I begin to plan more. I'm not sure if Norma and I will ever reach this co-leaderness but we do need to communicate more. Right now the only time we get together is to do our three monthly notes. When one lady from group came to me after group, it was cute because she said, "I've come to you because you appear to be the stronger leader." I thought that was really funny. One week when Norma was away, though, I actually missed her. She really is okay. By the same token, when I'm away, Norma usually reports having a terrific group.

So in fact, this is probably the group that I enjoy the most. It inspires me. You know that somebody's going to be in trouble each week. I wonder at times though if this is really fair to them. They're all a full focus for therapy. I actually have been thinking lately of offering some individual sessions to them. Probably this is out of my own frustrations. But maintaining them in this kind of group keeps them out of the hospital. And as for all their issues, there's always next week. Usually it ends quite well. You don't walk away worried about anyone.

Now I've got to get to my office. I'm supposed to

write a few things about what went on. And I've got a client booked in a couple of minutes. I've got to get out of here on time tonight. I'm helping my husband out at his store. He's understaffed. My life is more hectic than ever!

CHAPTER SIX: INTERPRETATION

The Researcher's Perspective

This chapter presents the second part of the findings that have emerged from my perspectives as researcher in this exploration of the experiences of an OT group. It begins with a summarizing discussion of the participants' experiences. The focus is on the commonalities and contrasts among the individuals' stories. The chapter then turns to a critical interpretation of these experiences from a client-centred perspective.

Discussion of Participant Experiences

The Community Living Planning Group - a safe refuge to disclose in confidentiality or a place to meet new friends? A way to gain improved health or just a way to pass the time? A method of encouraging clients to accept responsibility for their own lives or a place to provide a listening ear? It is a single group that is each of these and more. This second part of the findings will summarize these experiences through comparing and contrasting the participants' stories.

Leader and Member Stories Compared

John, Debbie, Maggie, and Lee shared their experiences of being a part of the Community Living Planning group. I had expected to find discrepancies in the perspectives of the leader compared to the members, as has been noted in studies comparing health care professional and client perspectives (e.g., Polimeni-Walker et al., 1992). There were such minor discrepancies as the details of group times, yet, commonalities among the stories of the three members and the leader were more notable.

All shared a similar sense of what it is like to live with a mental illness. Depression, a tendency to withdraw, and difficulties in just getting through the day were part of everyone's depiction. The basic structure or the format of the CLP group was also presented in similar terms regardless of who described it. Everyone described CLP as an ongoing group, with sessions typically consisting of members taking turns reporting their weekly goals and talking about related problems or issues in their lives. At times, structured exercise or "teaching" sessions are conducted by the leaders. Although these were not the words of all the study participants, on these features, everyone agreed. There is no doubt that all were talking about the same group.

This reality of the CLP group did not fit with the characteristic format for educationally-oriented groups

described in the literature. The sessions in which structured exercises were brought into group may have come closest; however, participants did not focus on these atypical sessions. This does not necessarily suggest that the CLP is unusual in its approach. The review, conducted prior to data collection, was based in part on my assumption that the educational focus of the group would be a profiled feature. This was not apparent in the presentation of the participants' experiences, nor was it explicit in the group's official description. The CLP may actually more closely resemble a supportive psychotherapy group (e.g., Frankel, 1993).

Common to all conversations was an emphasis, not surprisingly, on the perceived benefits of group. These were similar to the concepts labelled by Yalom in his seminal works on group psychotherapy as "curative" (1985) or "therapeutic" (1983) factors of group (Appendix L). Participating members and leader viewed CLP as providing an opportunity to talk and to be supported. No one offered to rank the benefits of group, but these two aspects, which seemed to be a blending of what is usually described as catharsis, cohesiveness, guidance, and instillation of hope were discussed by each participant. All but guidance have been found in other studies to be among the top ranked therapeutic factors in OT activity groups (Webster & Schwartzberg, 1992) and psychotherapy groups (Maxmen, 1973;

Yalom, 1985). Guidance typically is near the bottom of rankings in these studies of inpatients.

The only significant difference in terms of the group experience itself was that a major benefit of group according all the participating members was not acknowledged by the leader. John, Maggie, and Debbie all spoke emphatically of the relief of knowing, through their involvement in group, that "I'm not the only one" and that "they're going through what I'm going through." All stated that they knew before their involvement in CLP on an intellectual level that others live with mental illness and that others have fears and problems. It seems that only through the sharing experience of group that it becomes known at a deeper, and more significant level. Yalom labelled this universality. Debbie expressed this as the relief of realizing that she was not "some sort of alien being"; group provided a welcome to the human race type of feeling. Related to this is the sense of comfort (although not complete) and acceptance noted by all the members who shared their stories. The CLP was seen as a rare place where they could be themselves and could still belong. Certainly, Lee may have been aware of these benefits of group, but the noted discrepancy is more in terms of their relative importance. The members emphasized these features repeatedly; the leader made no mention of them.

What was surprising, however, was how few member-leader

discrepancies were revealed through the conversations. Lee did recognize some of the not traditionally considered functions of group from the clients' perspectives. She discussed, for example, that for some, the value of group lay in it being a regular social outing.

Member Stories Compared

More unexpected were the discrepancies between the experiences of members themselves. Members were painted in initial contacts with the leader and other staff as a relatively homogeneous group in terms of their life situations and identified needs. It was true that they were all in middle adulthood ranging from their early thirties to mid-forties and all lived with long-term mental illnesses. Each study participant's length of involvement in the group also fell in a similar range from several months to nearly a year. The experiences shared clearly show, beyond these superficial details, that the three members were not so homogeneous and that their stories illustrated a wide scope of perceptions of the group experience.

Debbie was a single professional woman whose fears and low self-esteem had kept her socially isolated. Maggie was a struggling single mother, in and out of an abusive relationship who aspired to regain the wellness she had. And John was on a disability pension and in the process of separating from his wife. He was consumed by his problems

and losses. Debbie accepted responsibility for getting better and took therapy, and this group, in particular, very seriously. For Maggie group played a relatively minor role in her life. Her desire to get better was strong, and she recognized some of group's benefits, but there were other means to her end. John liked group, but brought a very different personal agenda. It was a place to get things off his chest and relieve loneliness, but it did not seem to be seen as a means of achieving any significant personal change. Debbie was lost if group happened to be cancelled one week, John usually attended unless something else came up, and Maggie seemed to look for a reason to not attend. Debbie liked the lectures; Maggie did not. Socializing with co-members outside of the group was seen as a natural extension of group by John and considered to be "against the rules" by Maggie. The variations are innumerable. The CLP was clearly different things to these three different people.

The group was also different things to each person. Participants often related their experiences in contradictory terms. John insisted that "they don't pressure you there" but also spoke of discomfort when the leaders questioned him and he was expected to talk. Maggie on several occasions both said that she has and would "talk about anything in group" but also on several occasions stated that "there's certain things I won't talk about in

front of the men." Debbie said that she felt "guilty if I take up group time talking but I'm angry if someone else takes up too much time." These kinds of examples are abundant: "group's really helped" but "I'm not sure if group's helped"; "they leave it up to us" but "they make us do things"; and "I never think of group once it's over" but "I'm really worried about next week's group." Even Lee's conversations revealed some discrepancies; most notable were her feelings that "I've been stuck with this group" but that "I really like this group." My first reaction when noting such inconsistencies was suspicion. I wondered if participants were telling me, the researcher, what they believed I wanted to hear or if I was misunderstanding what people were sharing with me. Perhaps people were being less than truthful, or perhaps these discrepencis were a result of cognitive difficulties related to their illnesses. As the conversations progressed, however, and my relationship with participants developed, I came to believe not that people were being untruthful or that I was hearing incorrectly, but that people were merely sharing what was correct or real for them at the time we were speaking. These inconsistencies within people's recounting of their group experience were likely a function of the ambivalence they felt, and also a function of the changing nature of the group from session to session, and of their changing personal lives and state of well-being.

What were conspicuous for me in listening to the stories of those members who shared their life experiences were the commonalities. As conversations unfolded, I was often struck with a sense of deja vu. Even the words used were often strikingly similar. One area of mutuality was people's discussions of the experience of having a mental illness. People spoke of losses in their abilities, lifestyles and dreams, of the stigma of being thought "crazy," and of the times of desperation.

When reflecting on the group experience, members were also comparable in their perceptions of its more negative aspects. Although all characterized CLP as a comfortable place, feelings from mild uneasiness ("I'm never really comfortable there") to extreme discomfort ("It's all I can do to stop myself from leaving") were related. All members were also strikingly similar in having felt "let down" or "disappointed" by the group at times. In every situation shared, these feelings stemmed from having a co-member take excessive group time. The anger or disappointment would variously be directed at the member who was perceived as monopolizing group, at the leaders for not intervening, and at themselves, for not speaking up and saying what they wanted or needed to say.

There were some exceptions, but for the most part, the group members also shared a very similar sense of the aspects of the group experience that they liked, or that

they found helpful. These perceived positive aspects of the group experience seemed to fall within three categories: group as therapy, group as an activity, and group as learning. All participating members spoke, as already noted, of the benefit in being able to talk. "Opening up" and "getting things off your chest" were the most frequently discussed therapeutic features of group. This was consistent with Schultz's (1994) findings from a peer-support group for persons with head injuries in which expressing thoughts and feelings was ranked as the most helpful factor. The advise given by leaders and members, and the motivation or incentive that some discovered through their involvement were also some of the group as therapy experiences. Everyone shared "other people are worse than me" sentiments which served as inspiration ("I'm not so bad off after all") and fostered the previously discussed sense of "normalcy" gained through group. Finally, in terms of therapy, all members spoke of feeling accepted in group ("they don't judge or criticize," "It's the only place where I can be myself").

Community living planning was also perceived as beneficial to all because it acted as "something to do," and "a place to look forward to going to." Except for Maggie who was an infrequent attender, CLP formed a consistent part of the weekly routine and, as such, was seen as worthwhile. This aspect was not identified in any of the OT group or

group psychotherapy literature reviewed. This may be because most studies of group factors were with inpatient populations. Closest perhaps, were the OT studies whose participants identified group as being enjoyable or fun (Webster & Schwartzberg, 1992) and group as offering a break from the ward routine (Polimeni-Walker et al., 1992).

The group as a learning opportunity was identified by all members but was the least emphasized of the positive aspects of group. This was consistent with others who have pointed out that the teaching element within OT does not have the pre-eminence it deserves (Mocellin, 1992b). It was certainly contrary to my expectations upon entering the field and was also contrary to Lee's described vision of a more ideal group. People talked of "getting something out of listening to others," and of learning from the advice they received in group. Usually, this feature of group was described in rather vague terms such as "you can learn a lot from groups" and "I learn a lot from group, like how to cope," but members usually were unable to be specific. Only Debbie directly attributed her insight gained and the improved ability to communicate to her group involvement. The lectures and structured exercises seemed to be perceived positively more because they were interesting than because of the learning they facilitated. They offered a break from the regular goal-setting, turn-taking routine. Lee expressed doubts about the effectiveness of the more formal

attempts to teach in group. The low emphasis on the learning aspects of group by study participants may in part be explained because most of the educational opportunites within group were not labelled as such. There was a marked difference from the traditional view of teacher imparting information to learner. In every session people did interact, they problem solved, reflected, and practiced new behaviours; however, participants seemed conscious of learning primarily in the context of the structured exercises. Even Lee initially appeared hesitant to consider the CLP group as a candidate for this study because it did not regularly incorporate a structured approach to learning. The few educationally-oriented groups in the literature that did draw from adult education, for example, clearly demonstrated that education can and perhaps should stray from typical didactic/experiential approaches.

It was not intended that such a limited foray into these few people's experience of the CLP group would reveal any generalizable findings. The purpose of this study was to advance the understanding of the OT practice of mental health groups through understanding the experiences of three members and the occupational therapist leader of this one group. Chapter five's presentation of the stories of the participants and this chapter's discussion of some of the similarities and differences in their experiences has served demonstrate this understanding.

Interpretation of Experiences from a Client-Centred Perspective

In order to enrich the understanding of this group, discussion will now shift to an exploration of the findings from a client-centred perspective. Occupational therapy proudly describes itself as a client-centred profession but there have been calls that "it is time to begin the dialogue about what this client-centred approach means and whether or not we have captured its meaning in our practice" (Sumsion, 1993, p.6). This dialogue in the current literature focuses exclusively on the individual client-therapist relationship. No discussions of client-centred approaches applied to a group context were located despite the preponderance of group as a therapeutic modality in OT. The CLP group will now be held up to the scrutiny of a client-centred ideal.

Client-centred, as a practice philosophy, has been described in the discussion of this study's frame of reference. Essentially, it encompasses a cooperative client-therapist relationship grounded on the values of the client. Client knowledge and experiences are the focal point of this partnership (CAOT, 1994).

Consistencies with a Client-Centred Ideal

Upon embarking on the process of data collection, I had expected to discover major inconsistencies in group practice

with a client-centred ideal. Much to my surprise, instead I discovered what I have suggested are the fundamental requirements for implementing a client-centred practice. Central and essential to a client-centred practice from the time of Roger's inception (1951) to the present (CAOT, 1994) is a balanced relationship between client and therapist. Lee had incorporated these notions into her personal philosophy of practice. She talked of "trying to come across as everybody's equal," and the words of some of the members supported her view. Debbie, for example, expressed that "when they [the leaders] share a little bit about themselves, you get more of a feeling that, oh, they're human, that they're a person." She also made the point that "they're not up there." This seemed to near one of the dominant images of therapists as collaborator or friend that was found in Peloquin's study of client perceptions (1994).

The client/therapist relationship inherent in a client-centred approach also encompasses active client involvement and control of the therapy process. All study participants talked of how the group members had some control over the group. Members usually felt that they were not pressured to do anything (e.g., "They don't force you to say nothing, you don't have to say nothing"; "I've seen different cases where they say don't tell me, tell the group"). They seemed to have choice in determining their participation. Members were told by the leaders that CLP was the members' group,

that decisions on what happened in group were their own. Norma talked of how she would "give it back to the group, and say, this is your group ... you decide if this is acceptable." Even when in opposition, Lee had conceded to the group's wishes (i.e., "I was kind of against it but the group voted on it"). Often the leaders' agenda, especially the structured exercises, would be set aside because of the members' needs to talk.

As Lee discussed her disagreements with members, a degree of respect for members' values became evident. When she talked of people who primarily seemed to use group as a social outing, it was obvious that she did not personally support this as an appropriate use of group but nevertheless, she condoned the practice. In some OT literature (e.g., Polimeni-Walker et al., 1992), in areas of disagreement between therapist and client, authors have concluded that there is a need to educate patients as to the "real" or "correct" reasons for attending group. Lee, however, did demonstrate respect or at least acceptance of client values by conceding that this may be valid for those individuals and allowed those people to continue to attend.

All members who remained as study participants also demonstrated a certain amount of control through the process of being referred to group. On a fundamental level, their arrival in group was a result of their own initiative. Tales of repeated requests for help, changing doctors to

find one who would make the required referral, and specific demands to be sent to the clinic were recited. Ultimately, as well, it was each member's choice to remain or leave group.

Some of the leaders' approaches within group may also be seen as consistent with client-centred practice. All members felt, at least most of the time, that they were not "forced" or "pushed" by leaders. This was certainly both leaders' intents. Lee characterized her approach as offering "both sides of the coin, or more than one idea that they can select from. The selection is theirs." She also spoke of how she tryed "to encourage them to please themselves, not the leader" and how she shared information such as material from a suicide intervention workshop with clients. Norma also saw herself offering alternatives to the group and commented that "who knows their own needs best but the people in the group?" Lee, in her characteristically forward manner stated that she "often tell[s] people that we are their servants. That in fact they pay our wage. And they have every right to make demands." Lee also talked of her recognition of the importance of "going to the group to see what they need." The OT literature provides ample evidence that therapist values are generally consistent with a client-centered frame of reference (DePoy, 1990; Fondiller et al., 1990).

In recent study of therapists' clinical reasoning,

however, Fleming (1991) revealed a devaluing of interactions with clients, well portrayed by one therapist's account of her guilty feelings after talking with a client and reaching improved mutual understanding rather than doing her "job." Some therapists see their relationship with clients as an adjunct to therapy and consider personal discussions to be inappropriate. Fleming discussed this as a conflict within therapists between a medical model and a humanistic perspective. Is their role to treat the problem or to treat the person? Peloquin (1993a) described this as a discord inherent in a profession that is committed both to competence and caring. Lee, however, interacted with members outside of group, from sharing smoke breaks with clients to after group talks in her office, and did so without apparent guilt or need to justify. Obviously she valued this interaction, which is necessary in developing the understanding required of a client-centred approach.

This discussion has highlighted some of the features of the group experience that suggest CLP's consistency with a client-centred practice. Leader understanding of member views, attitudes demonstrative of an equal relationship, and some active involvement and control of the group process by the members emerged.

Inconsistencies with and Barriers to a Client-Centred Ideal

Although there were many positive features of the CLP

experience in terms of consistency with a client-centred philosophy, there were also many limitations revealed. In the telling of the experiences of being a part of group, the study participants revealed diverse aspects that seemed inconsistent with a client-centred practice, or that potentially acted as barriers to such a practice. This was not unexpected. There is ample evidence in the literature of therapist practice that has been found to be much less than client centred (Jungerson, 1992; Nelson & Payton, 1991; Peloquin, 1993a; Rogers & Masaganti, 1982). Aspects ranging from the attitudes of the study participants through to larger systems issues will be reviewed. The focus will then turn to the events within the group itself.

Client and therapist attitudes. The attitudes or beliefs of the participants involved in this study have been described as being somewhat consistent with a client-centred framework. There are, however, some details within the data that suggest contradictory attitudes. Health care professionals are often seen as accountable for the lack of client-centred practice, especially in terms of their attitudes (Abramson, 1990; Bartlett, 1989). It would seem that the leaders of the CLP were no exception.

Some clues were revealed in how leaders spoke of the members. Lee, when talking about her caseload in general or her domain of clients, used a variety of descriptors such as "the chronics", "the hopeless" that suggest anything but an

equal relationship base. Never did she speciifically refer to group members in this manner, but in her conversations the distinction became blurred. Both leaders referred to some of group members and things they have done as "cute". Although this may be just a manner of speech or the commmon language of the setting, it is not usually considered appropriate in the context of referring to an adult that one respects.

Contradictions with earlier suggestions of a client-centred attitude in the leaders is best illustrated by a comment made by Norma. She followed some of her statements noted earlier about group members knowing their needs best by then saying that it was her intention to "try to make them take responsibility." Forcing anything upon clients, even if in the guise of it being for their own good, runs contrary to client centredness. Group members, however, did not raise any of these concerns.

For the most part, Lee seemed to have a good understanding of group as experienced by its members. The one conspicuous exception I noted was her reference to group as a "lifeline" for its members, that for most, it's "all they've got." I entered the conversations expecting a similar portrayal by the members. For some this may have been true, but it was not characteristic of those who participated in the study. Maggie, for example, placed group low on her list of priorities in her daily life and in

her treatment. For John group may have been more important but seemed to pale in comparison to the social contacts he orchestrated outside of group. Group may have been most important to Debbie, but again, she was involved in other counselling and in her career; group was certainly not all she had. Lee seemed to represent what has been suggested by Helfrich and Kielhofner (1994) as a typical view in OT of the client coming into therapy rather than therapy coming into the life of the client.

On the other side of the relationship were the group members who brought barriers of their own. It has been suggested in the literature that there is a poor match between client-centred values and client desires for high technology and "quick fixes" (Evert, 1993). This does not appear to be an overly relevant factor in the CLP members. Only Maggie hinted at longing for a quick fix in her contemplation of requesting ECT. She was also the member, though, who focussed the most on the importance of time as part of the process of getting better.

Much of the client-centred literature focuses on obstacles, especially a loss of personal control, resulting from the client's physical and mental condition (Abramson, 1990; Gray & Doan, 1990; Gray, Doan, & Church, 1991) and lack of social support (CAOT, 1994). The balanced client-therapist power relationship required can be particularly difficult when the client is mentally ill (Burgess & Burns,

1990). The mentally ill can be especially powerless. Clients in mental health are those that have often been "dismissed, denied, disenfranchised and who have little hope, control, resources or social structures for making changes" (CAOT, 1994, p.12).

Feelings of powerlessness and victimization did pervade some members' conversations, and conceivably limited their ability to participate in a balanced leader-member relationship in group. People were overcome and consumed by their problems, fears and life situations. Group members presented themselves as lacking control across an array of issues from dealings with an insurance company ("They don't give a shit") to dealing with one's own feelings ("Those feelings...I guess they're going to be there. Not much I can really do about it"). All members described their self-esteem, not surprisingly, as low. The development of these kinds of feelings and perceptions is complex and because the focus of the study was on the immediate experience of the group, most participants did not relate at any length their personal histories. What they did share of some of their experiences outside of group does serve to explain in part why their attitudes may be less than client centred.

Outside experiences. One outside experience that all members did discuss was their past involvement with the medical system. Usually, this was described in negative terms. Maggie, for example, shared the long-lasting effects

of having information withheld from her. She was being treated for liver disease: "They did all kinds of tests, and when they let me go, I didn't feel any better. They didn't tell me that it would take a year to recover completely from this." As her symptoms persisted, she became disabled by her fears of dying. This has been discussed by consumer advocates (e.g., Deegan, 1992) that counter the innuendo either that the client is to blame for not being more active or that a non-client-centred approach is necessary in certain conditions. Deegan argued that such obstacles within the client are the result of oppressive environments and treatment, not a result of the illness itself.

Even in instances members shared of taking control of their health needs, the responses they received were all but reinforcing. Debbie addressed this as she related her early help-seeking attempts: "But I felt I was getting worse and worse and worse. And the doctor told me to just go back home and that would solve everything." Such non-active responses or inadequate suggestions could have undermined her sense of self-knowledge, and devalued her experiences. In this case, however, the doctor's reply provoked a sense of outrage in Debbie and motivated her to continue to seek help. She then located another family doctor who seemed to take her mental health concerns seriously.

Another participant who withdrew in the early parts of this study, although new to the mental health system,

epitomized the "passive patient" stance that some suggest is typical (Sharf, 1988) and others suggest is a result of the socializing process (Matheis-Kraft et al., 1990). He trusted experts to tell him his needs and expressed a sense of relief when "they" took control. Despite having no past history of work difficulties, on his first contact with a psychiatric setting, he related that "they're telling me in no way will I be ready to go back to work for awhile. So I don't really believe that I'll be going back to work at all." John also accepted his doctor's prognosis that he may "never get out of this rut." This kind of hopelessness may not be characteristic of mental illness but instead, may be a result of treament.

The disparity between client-centred practice and the health care system is well recognized (Carswell-Opzoomer, 1990). The medical environment in general has been identified (Stern & Restall, 1993), and more specifically, institutional attitudes (Abramson, 1990). There is an historical basis for these barriers. Original American hospitals in the 19th century were organized according to an authoritarian military model which stripped individuality. These effects were intensified by the strong influence in the following century of the scientific model which forced the patient into a passive role (Boumbulian et al., 1991). Goals related to empowering clients may be at philosophical odds with the medical model expectation for compliance

(Fahrenfort, 1987). It is not surprising that past experiences of group members and to a lesser extent, the therapist, have done little to prepare them to expect or participate in a client-centred relationship.

Further to these kinds of immediate experiences, there was also a sense of abandonment or exclusion from good care and services by the members. In this area of the province, there have been longstanding difficulties recruiting and retaining health care professionals. There is a high turnover of doctors, especially psychiatrists. Many stay in the area long enough to collect their government grants then migrate to larger centres. One group member talked of his first psychiatrist who "was also leaving, she went down south. All our other doctors are doing it." This may have left the group members, as most residents of such communities with a sense of no choices. One must accept the care offered because there are no other alternatives. Certainly this seemed true with Maggie who clearly wanted a different kind of help but accepted the CLP. It was surprising and perhaps hopeful that Maggie, Debbie, and John all described circumstances where they either refused to see a certain doctor or they sought out different doctors more appropriate to their needs. Experiences shared by the members of treatment outside of the group suggest that a client-centred approach is not encountered.

The entry to group process. As group members talked of

their experiences more immediate to the group, inconsistencies with a client-centred approach continued to be revealed. To get to the clinic, clients needed to have a referral from a professional. Thus, from the very beginning they were given the message that their opinion needed to be validated by that of an expert.

Once in the clinic, for some, there was an apparent sense of being powerless or of being of little significance. John found that with the previous group he was involved in and enjoying "they had to cut that group out because they were cutting back on budget or something." Individual wishes or needs did not seem to be a part of the consideration. Both John and Maggie felt they needed individual counselling but "knew" that it couldn't be offered because "they are so busy down there."

These comment suggest larger economic issues which are also often discussed in the literature as factors in non-client-centred practice. Boumbulian et al. (1991) lamented the negative impact on quality of care in a health care industry that is being pushed to attend only to the "bottom-line." Peloquin (1993b) also blamed a health care system driven by efficiency and profit for leading to a preference for competence over caring. The health care system is criticized for losing its sense of purpose though efforts to respond to economic and other pressures (Bartlett, 1989). Health care exists to serve people's health care needs, yet

it is moving from "service" to "industry." An "efficiency" perspective is seen a putting quality of care at risk (Schwartz, 1990). According to John, this was the very reason for offering help in a group format. Even Lee thought that efficiency considerations were where the idea of groups at the clinic originated.

The feeling of having no voice or little control at the clinic even extended at times to the leaders. Lee spoke of several instances of the clinic deciding to do things and her resent at her suggestions in the past being ignored only to be raised by others years later. These, however, were balanced by ample illustrations of situations where she was able to influence clinic procedures.

Although members controlled much of the process of getting to the clinic, professional control pervaded members' descriptions of the process of actually entering group. John and Maggie give two typical examples of their perception of how they came to be in the CLP group: "I had an interview with a woman in there, and she puts you in the group that she figures would be good" and "I think she took down information from me. Then they had a meeting, I guess, and then they called me back in and she suggested that I go into the Community Living group." The decisions were made by "them," the clinic staff. The process of becoming a group member for Debbie, however, differed markedly. When "they thought I was ready to get into a group," recounted

Debbie, she agreed but described it as "one of these things that I did because they felt I should." There is a sense of pressure if not coercion. The selection of the group itself was left to her with some information provided by her counsellor. Debbie explained that "they asked me if I wanted to come in this group or this other group. And I went and chose the other group. Wrong choice." Offering choices inevitably means that "wrong choices" will be made but I was not certain that Debbie was given adequate information and support to enable an informed decision. Informed consent can be defined as a collaborative, decision-making process which permits real understanding of the treatment intervention (CAOT, 1994). Although this incident was described as a traumatic and stressful experience by Debbie, it did not alienate her from the clinic or from eventually repeating the risk and entering the CLP group which she generally perceived as being a helpful and necessary experience.

Not only did members relate experiences of not having choices within the clinic, but some also described an awareness of being talked about without an opportunity to participate in the discussion. Debbie said "I think they talk when they're all together. The psychiatrist seems to know where I am, what's happening in group and I haven't told him." Debbie seemed to accept this as the norm. John, however, appeared distressed when he realized that this

occured upon reviewing this study's findings. Collaborative or partnership relationships with clients has not been adopted in the functioning of the clinic. This example is not unusual in practice. Roback, Ochoa, Bloch and Purdon (1993) found that mental health practitioners rarely inform clients of confidentiality limitations.

It is interesting that entering the clinic and group was perceived by Maggie and John as being controlled by staff but both felt free to attend sessions as they pleased. Debbie chose the group but at one point was required to signed a contract that she remain. She described it as a "you're going" directive. Although she discussed it with a sense of humour, Debbie felt certain that for a period of time, the contract was the main reason for continuing to go to group. This was no longer a factor in her attendance and she seemed to have appreciated this intervention.

I had anticipated that the physical setting of the group would be an issue for members. As an outsider entering the facility, I was struck by how much the building seemed to belong to staff. The receptionist sat protected behind a glass barrier and the door providing entry to the offices and group rooms was locked to clients at certain times. The setting seemed cold, both literally because of the air conditionning and in a clinical sense to me. The contrast between staff's collegial conversations in the hall and movement from office to office on the inside, and the

clients patiently seated on the outside, seemed marked. Other than Debbie's suggestion that the room lights be dimmed, and John's wish that the group be held out of doors on occasion, the setting did not seems to be a major issue for participants.

Members did, however, all talk of the stigma they felt because of their involvement with a mental health clinic and, by association, their psychiatric diagnosis. Maggie talked of "people see me going in there, they're going to think I'm crazy," John felt reminded of his shame at his situation of needing psychiatric help each time he entered the clinic, and Debbie felt "hassled" initially at work because of her co-workers knowledge of her being in therapy. All seemed to have resolved this to some degree and were accepting of their need to attend the clinic and as a consequence were regularly reminded of their patient status.

The accepted understanding of the group from the clinic staff also gave the impression that it ran contrary to a sense of its members participating in a collaborative venture. Community living planning was described by Lee as the "bottom" of the group structure at the clinic, and its members as low functioning. She even confessed that her first reaction to becoming leader of the group was "oh my god! How did they stick me with this sucker!" This initial reaction seemed to be based on preconceptions and did not hold once she was able to actually experience the group and

come to know its members. None of the members were aware of the official description or objectives of the group. Debbie had also described CLP as low functioning; this is how it had been presented to her by her counsellor. When I shared with her the clinic manual group description (Appendix C) and asked for her comments, she was obviously taken aback and seemed offended. Her response was that "we're all higher functioning than that!". In conversations with Lee, it did seem that the level of the group had shifted upward, but somehow the group's history seemed to continue to colour people's perceptions of it.

There was also the belief by most participants that group as a therapeutic medium, was "second best." According to Lee, when staff were "fed-up" with clients or had tried "everything," they might refer them to a group. Both Maggie and John did not have a counsellor at the clinic but saw individual therapy as more appealing than group. Debbie, however, perceived her individual counselling as serving a different, not better or worse, function than group.

These kinds of factors within the study participants and the experiences outside of the group session may have acted as barriers to a client-centred approach. An examination of the experience of the session itself reveals further barriers and discrepancies.

<u>The group session.</u> The group sessions were the focus of most participants' conversations. As has been discussed,

some indications of a client-centred potential were revealed, but the experience of group for the most part seemed to have suggested a reality far from the ideal.

A striking feature was never directly discussed by any participant but was pervasive throughout all conversations. The group did not seem to be perceived as belonging to its members. There was a statement or two by the leaders that CLP was "their" (i.e., the members') group, and the very rare "we/my/our" type of reference in relation to group in conversations with the members. Lee, however, was noted to refer to the CLP as "my" group or "the" group, but more telling was the members' almost exclusive discussion of group in terms of "they" not "I/we" and "theirs" not "my/ours." This suggested that "ownership" of the group was vested with the leaders.

The concept client-centred implies more than ownership. It implies therapist-client collaboration throughout the entire therapy process. It has been shown that this is a key determinant of the effectiveness of therapeutic programs (Falloom & Talbot, 1982). As was discussed earlier, members were told and did communicate that they exercised some control over the group. John noted that "the group leaders they more or less leave it up to us." "More or less" may be the telling clue as there were many indications that the CLP was in fact strongly leader driven.

There were many situations described that suggested

that only token control was given to members. Immediately following her characterization of CLP as the members' group, Norma went on to say that if the members made a decision that leaders did not agree with "we'd make them look that this wasn't realistic." An apparent approach consistent with a client-centred philosophy was negated by incompatible intentions. This is not uncommon in practice described in the literature, especially in nursing (Burgess & Burns, 1990; Kasch & Knutson, 1985). The clear message was that the leader knew best.

The members also did not appear to exercise any control in the composition of the group. New members were admitted to group by the leaders without consultation with current members and apparently without even informing members. "New faces" coming in to group were of special concern to the female members. For both Maggie and Debbie, the changes in group through new members were seen in negative terms. For Maggie in particular, the unexpected arrival of men changed the rules; she had believed CLP to have been a female only group.

There is little doubt that members viewed the happenings in group as being orchestrated by the leaders. A major focus of group was goal-setting. The members' accounts speak for themselves: "We'd come in and they'd do the goals. And then they'd go on to something else. And they kind of changed the goals to the end. Now they changed

it again" and "They set goals. They want you to set a goal for that week. They do that every week." This experience seems especially ironic when, traditionally, active involvement of the client in the therapy process is usually limited to goal setting. Even literature advocating increased client participation often focuses only on goal-setting (Nelson & Payton, 1991). Despite members identifing their own goals in group, there was the sense that goal-setting was something imposed on them.

A non-client-centred tendency was also noted in documentation about the group in the medical charts. Although it would have been shocking to find otherwise, it was the leaders who did the documenting, so their perspectives prevailed. The manner in which goals were addressed in the charts illustrated this tendency clearly. Despite the members' identification of goals acting as the core of the group format, rarely were these even noted in the charts. Instead, quite consistently, the documented plan included leaders' statements such as "... will continue in group" and "...encourage her to attend CLP." There were no indications that these plans were agreed on by the member. The preponderance of "keeping patients in group" type of goals seemed to be directed more toward leader needs than toward member needs. Of course, the client needed to remain in group to be helped by the experience, and in fact, premature termination is how failures of group psychotherapy

are often defined (HarPaz, 1994). If this was a collaborative relationship between members and leaders and the members' needs were being addressed, however, it would be unlikely that they would be at risk of departure. There seemed to be a reluctance to consider that options outside of group could be appropriate. It occurred to me as reading the charts, that in an ideal client-centred situation, the leaders' goals should include getting members out of group rather than keeping them there. Lee repeatedly talked of members' lack of supports and it has been suggested that client-centred practice involves assisting clients in developing required supports (CAOT, 1994). One method of accomplishing this is preparing clients to be able to participate in self-help organizations. Lee's comments such as "I'm not sure what's really happening there" in reference to a self-help organization suggests she was skeptical of this option. She questioned the quality or appropriateness of the help these groups offer. Only once was "developing supports" noted as part of a documented plan. Dependency on group may have been unwittingly encouraged.

The leader control, or sense that leaders "do to" rather than "do with" members extended beyond the goal-setting routine. "They give you advice"; "they like to see everybody have a turn"; and "we had to discuss" are the kinds of phrases that pervaded the members' accounts of their experiences. Even parts of the leaders' accounts echo

this. Norma shared that "we'd make them fill out ... and then we can set their goals" and "we bring the exercises in whenever we see the need." Lee, however, seemed to recognize this tendency and tried at times to act against it. She disliked the goal-setting routine, for example, that lead to "the same old pattern of them having to do something to please me." When members did control the group, it was not usually done openly. On occasion, goals were set aside or a teaching agenda postponed because "everybody kept talking."

All three members shared examples of group situations in which they refrained from saying or doing something. John's account serves as one example. He talked at length of wanting to organize an outing for the members. He checked the idea first with leaders outside of group and recounted the experience: "So the leaders told me to bring pictures in. I did. Nothing was mentioned. The pictures were left in my pocket because I didn't want to interrupt by bringing them back out again. Nothing's been mentioned since... ." All three spoke of times when they had wanted to suggest an option to a co-member but had not felt comfortable enough to do so. For some reason, members are reluctant to act on the "permission" they had been given to control the group. There are likely many reasons for this. Some reasons have been identified (CAOT, 1994): lack of experience, cultural attitudes, severity of mental disorders

or problems, and role expectations among others. Maggie talked of being raised to "listen to her elders", John felt that it was not his place as a patient. Lee did not discuss this in relation to the CLP but did talk about some enlightening feedback from another group at the clinic. Those members, even though they at times had something to contribute, thought as did John, that it was not their right to add a comment or solution based on their own experience. They felt that the leaders were the professionals. Lee described this feedback with a sense of disbelief. Issues related to power and control in the patient-therapist relationship are key as the term professionalism itself implies expertise, control, and decision making (Bloomer, 1978).

The contradictions within and between experiences already noted in the discussion of the participants' experiences, however, suggest an additional explanation for members holding back. Perhaps the messages members received were contradictory. The verbal and non-verbal indicators received by the members that communicated that it was not the members' group may have been stronger than those giving them permission to take control. When John reflected on his reasons for not bringing up the topic of a group outing, he said that "they [the leaders] would say to the group, `well okay, John wants to ask you something.'" The leaders still would hold control as gatekeepers.

Lee also observed that members "hate to take time from the group when someone may have a more important topic." This seemed to be an important issue for John, Debbie, and Maggie. They all spoke of this from the perspective of the guilt they felt when they took too much group time. Lee considered this a "kind of wierd issue." Her described response, in a different group from CLP, was that "we reinforced that one week it's your group, next week it may be his. It'll all even out." This seemed comparable to the CLP experience. Members all echoed the kinds of responses that Lee gave to her other group. When they spoke of the resentment felt when a co-member dominated group time, usually, it was followed with a statement such as John's comment that "it's okay, because maybe next week it'll be my turn." This reinforced a notion of time as a valuable and limited group commodity. Whether it is measured over a single session or several sessions, there was no suggestion by the participants that group time was "ours" or shared. Leaders allocated this resource and members clearly felt that the benefits of talking, for example, outweighed the benefits of listening or offering advice to others.

The lectures, or structured exercises that were offered in group seemed to have had the potential for empowering members. Lee's intent was to focus on skills that members could immediately apply to their life situations. The approach taken, however, seemed, as with most educational

practice in health care, to be based on the assumptions not only that members do not have that knowledge, but that they are not capable of teaching themselves. Although Debbie thought that the leaders would put together a session if requested by a member, the topics and the timing of all the concrete exercises discussed had been determined by the leaders.

Interaction within group by all accounts, was predominantly leader to member. Lee recognized this but justified it in stating "what's the harm as long as everyone has an opportunity to talk if they chose." The harm, perhaps, is in the missed potential. Technically, this format did not even fit the definition of group in which a common purpose is attained through members interacting (Howe & Schwartzberg, 1980). Members were not allowed to experience the altruistic experience, described by Yalom (1985, 1983), and recognized by Lee as the "sparkle in the eye" when members shared their learning with others. For John, attempts at organizing social activities outside of group were motivated in part by his recognition that "it feels good to help others." Even the benefits of ventilation or open expression of affect (i.e. catharsis) are recognized as rarely lasting (Yalom, 1983). The turn-taking format also seemed to be limiting as it was the main method of control by the leaders. Leaders decided how much time was alotted to each member. All members described

their typical behaviour in group as sitting, listening to others and awaiting their own turn. This likely prohibited cohesiveness and did not reflect a collaborative venture.

Lack of member solidarity. On average, approximately seven members and the two leaders attended each session. The adage that there is strength in numbers did not seem to apply in the CLP situation. I had expected to discover instances of the members acting as a whole to determine the group's direction. In all of the conversations, only one example of such behaviour was described. Members apparently bonded together to denounce what they saw as an inappropiriate analogy used by one of the leaders. The members' perceived lack of ownership of the group, as already discussed, likely was a factor in this not occurring more often. Members also seemed to hold different expectations of what group could offer. There was no uniting under a common goal. All members also talked of not knowing each other that well. Perhaps most significant, though, was the theme already noted that emerged repeatedly in the conversations - time. Each member had a "right" to equal talking time and leaders controlled its distribution. Members described feeling angry toward one another when it was perceived that someone had taken more than his or her "share" of the group time, whereas a session was generally rated as "good" when everyone had the opportunity to talk. There was the implied attitude that if one person was

getting help, then the others must be missing out; a covert competition seemed to be the result.

Inter-leader discord. Many of the issues that indicated a possible inconsistency with a client-centred practice or barriers to such an ideal have been discussed as they were revealed through the data. One of the more significant barriers, in my opinion, related not to member-leader relationships, but to the relationship between co-leaders. When Lee noted "I'm not sure Norma and I will ever make co-leaders", she reflected my own thoughts as researcher.

Group members all talked of the differences between their two leaders. Everyone agreed that the two were of very different personalities. One even saw this as a complementary combination. John mentioned several times that the group operated very differently on the occasions when only one leader was present and both leaders also spoke of running things differently when on her own. No members, however, acknowledged or even hinted at any awareness of conflict between the leaders. This theme did dominate Lee's conversations about the group, as it did my perceptions upon observing a session.

Lee's descriptions of the rare interactions between leaders outside of group, her characterizations of Norma, and her apparent attempts to explain or justify Norma's approach all suggested serious conflict between the two.

There was no indication that this conflict ever was addressed openly. Norma's detailed discussion of how members reacted whenever a new leader joined her in CLP provided the only clue that members may have been aware of this issue. Norma suggested that members put her in a position of authority by focusing on an area of expertise for her such as medication. Apparently, she believed that the group wanted her to remain the dominant leader.

Although this conflict seems to have remained covert, as an observer to the group, the discord seemed all but hidden. I was shocked by the number of times leaders pursued different avenues (e.g., Lee's attempts to question cut off by Norma's change of topic), offered conflicting advice (e.g., Norma advising a woman to consider a boyfriend's advances as a compliment versus Lee's suggestion that this woman proceed very cautiously in the relationship), and even indirectly reprimanded one another (e.g., Lee's laughter was prominent as the group chuckled with a member of the group but Norma scolded the group for taking what she suggested was a serious situation lightly). These examples came from the single session that I observed; a situation in which I would expect leaders to have been on best behaviour.

It was not all conflict in group. The leaders seemed to have attempted to share, however briefly, plans such as an exercise that they were about to bring into group. Lee

talked of instances where she has rescued Norma, and times Norma has given her positive feedback following a session. I also noted a few incidents of leaders shifting stance in group to support the other leader. These rare instances did not seem to nearly compensate for the amount of discord.

I wondered if this leader conflict may have contributed to the sense that CLP was not really the members' group. Comments such as Lee's that "I'd decided that I'd had enough of whatever it was she's doing, that I was taking this group" suggest once again that group was owned by the leaders.

Difficulties in harmoniously working together have been recognized in the literature (O'Kelly & Azim, 1993). In the CLP, power struggles, inconsistent approaches, and a lack of common philosophies all seemed to characterize the nature of this co-leadership. It is difficult to imagine how a collaborative relationship with the members could ever be fostered in a situation such as this where leaders are apparently battling for control and not able to model a partnership.

Summary

This discussion and interpretation of the group from my viewpoint as researcher with a client-centred perspective

has served to extend the understanding of this experience. I have suggested that although some fundamental prerequisties to a client-centred approach were present (e.g., therapist attitude, therapist understanding of client perspectives), they were overshadowed by incompatiblities external to and within the group. These potentially formidable barriers to a client-centred practice included factors ranging from previous health care experiences, to procedures for referral to group, through to the structure and co-leader discord within the group. I expect that there may have been other features that did not emerge because the focus of data collection was on the immediate experience of the group. Other research into client-centred practice, for example, has shown that some therapists feel inadequately prepared in the required skills (Lysack, Krefting, Stadynk, Paterson & Harvey, 1993).

The perspectives presented in this chapter were not returned to the participants; they solely reflect my own interpretations. Many of the issues in this discussion were not even raised by the participants. I am aware of the dangers of distorting the understanding of this group through my own assumptions. I am also aware, however, that the participants are also living with their own distortions. This interpretation could be viewed as an unfair attack of a group practice that never even purported to represent a client-centred approach. The intent was not to suggest that

there is anything inherently right or wrong; the intent was merely to deepen understanding of a conventional OT practice. What becomes clear is that the CLP group was a complex multi-faceted experience. Just as the essence of the profession's espoused client-centred approach is difficult to articulate, so may its application to practice be elusive.

CHAPTER SEVEN: SUMMARY, DISCUSSION AND IMPLICATIONS

Summary and Discussion

My intent in this study was primarily to understand the experience of an educationally-oriented mental health group from the perspectives of some of the group members and the occupational therapist leader. I also aimed to explore the extent to which this group appeared to have reflected a client-centred practice. In this final chapter, I will summarize this work and will discuss its implications.

The study was rooted in several sources as described in chapter one. A trend toward increasing the focus of client centredness in OT practice was discussed. Only limited related research exists in the professional literature and a near absence of discussion or research on client-centred practice in the context of group therapy was noted. This study also stemmed from a personal quest. It grew from my conceptualization of therapist as teacher: a conceptualization consistent with the profession's identity, and from dissatisfaction with my own attempts at educating clients in group settings. I wanted to better understand this kind of therapy experience so that I may work toward enhancing my own ability to facilitate the educational process in groups and to do so in a manner consistent with a

client-centred philosophy. This client-centred practice philosophy was described in the second chapter and presented as the study's guiding frame of reference. An extensive review of related literature (chapter three) provided a portrait of typical educational interventions in health care, especially groups in OT mental health practice.

My purpose in this research was to gain practical knowledge with the intention that this was not an end in itself, but an important piece en route toward emancipatory knowledge. The methods used were interpretive: my guiding beliefs, emancipatory. In chapter four I described the methodological decisions made through the research process from the selection of the group and the study participants through to the analysis procedures. I incorporated my rationale in terms of ethical and trustworthiness considerations into this discussion. My emphasis throughout the research process was on creating a collaborative participant/researcher relationship. A number of limitations to this were recognized. A series of conversational interviews with three of the group members and the OT leader served as the primary data collection method. This information was enriched through my observation of a group session, through a review of related documents, through supplementary interviews, and through my fieldnotes. The process of coding, participant feedback, and reflection, enabled me to recreate in chapter five, the

experience of the group which I presented as participants' stories embedded in a representative group vignette. I then discussed in chapter six some of the salient features of the participants' experiences according to my perspective as researcher.

The group was ongoing and met once weekly at a community mental health clinic. Its purpose was to provide support and to assist people with long-term mental illnesses to structure their time through the process of setting goals. For some members, it was a regular part of their weekly routine. It was a place to go where their sense of aloneness or uniqueness was reduced, where they received advice on current problems, and where they might learn some things to help them cope. Occasionally, leaders introduced structured exercises specifically aimed at this learning. Primarily, however, group was a place for members to unburden themselves: a place where they were permitted to talk. Ironically, members did all withhold their participation at times. For the therapist, there was an ongoing struggle to balance members' needs to have their time in group, and their needs to develop skills. The group was also shaped by relationship issues between the co-leaders whose divergent styles and aims created covert conflict.

In chapter six I moved on to critique this group experience from my interpretation of the client-centred

frame of reference. The critique revealed some compatible features with client-centred practice, but also an overall sense that the group functioned far from the ideal. It was not consistent with collaborative relationships in which group members carried significant authority, nor was this group based to any great degree on the members' knowledge and experiences. Some of the therapist's guiding attitudes, however, were consistent with a client-centred philosophy. The leader valued the client and an equal relationship, and seemed to possess an understanding of the clients' experiences. Many factors were revealed that may have contributed to this discrepancy. Personal and environmental factors were discussed as well as factors within the group itself (e.g., leader control and ownership of group, lack of member solidarity, competition for time, co-leader discord).

I had entered this research with three preconceptions; this exploration only confirmed one. The educational process did not emerge as a dominant theme. It seemed more important for the therapist as a part of her improvement plan for the group, but was only of minor importance as the members recounted their experience of group. The client and therapist perspectives were not widely divergent as had been expected, and in fact seemed remarkably similar. Finally, the group experience, as I had anticipated, only seemed to feature minimal consistencies with a client-centred approach.

For the remainder of this final chapter I will discuss the critical question that remains: Of what significance is this study?

Implications

The significance of this study may be evaluated in terms of anticipated or actual implications. Traditionally, implications of a thesis work are considered in relation to practice, theory, and further research. I too will discuss these aspects, but in recognition that the essence of this work was located at a much more personal level, I will also discuss implications to the people involved in the group and to me.

Practice

This study aimed toward understanding; it was not intended to produce direct and immediate implications to practice. The complexity of a client-centred ideal and the diversity of practice situations render it impossible and perhaps undesirable to extract a guiding heuristic from the findings of such a study. What emerges from these individuals' experiences of a single mental health group, however, are a deeper understanding of practice and a multitude of compelling questions and issues. The study's

strength is in its potential through these questions and issues to foster a reflective process in therapists. This process, ideally, will bring about enhanced practice.

These implications relate most directly to OT practice in areas similar to the study's focus. Most questions and issues, however, also extend far beyond groups comparable to this community mental health OT group and could be significant to group practice in diverse situations, to mental health practice in general, to most other areas of OT practice and perhaps even beyond.

Contemplation on the process of the CLP group, or how it operated, serves to illustrate how this reflection could unfold. Knowledge is well recognized as a source of power (Kincheloe, 1991) and collaboration is fundamental to client-centred practice (CAOT, 1993), yet many of the decisions and background information related to this group and its members were the private domain of staff. Much of the process within the group was also hidden: Aims were not discussed, dissatisfaction and discord remained covert, and members seemed to secretly compete for group time. The very concept of group implies interaction, yet true dialogue requires openness (Mezirow, 1991) and shared perspectives (Hasslekus, 1988). These kinds of common norms or acts of condoning these norms surely served to undermine the group potential and prohibit collaboration. Group was basically consecutive one-to-one dialogues between leader and member.

This turn-taking format was even written into the official description in the clinic's policy manual. When individuals are dependent on experts to run groups, their personal authority is undermined (Kincheloe, 1991). Everyone agreed that there was immediate or short-term benefit to this practice, yet there seemed to be the perception that this talking time was occurring at the expense of teaching time or of others' talking time. Could the leaders have sought or created opportunities in group for the members to have real choices and authority? Are there ways that the leaders could have facilitated rather than controlled the dialogue? Perhaps the leaders could have assisted members in developing the required interaction skills so that discussion could move away from the established dyadic model. Perhaps members could have been directly involved in making decisions about time use in group. Perhaps the ensuing dialogue could have been shaped into a learning environment. Reflection on these kinds of queries could point to ways that group can be <u>done with</u> all members and not <u>done to</u> individual clients.

Through consideration of the experiences that emerged from this study, many other potential warning signals are apparent. These group experiences have the potential to act as mirrors with the nature of the reflection varying according to the viewer. For me, many questions related to facets of my own practice surfaced: How informed is the

consent clients give to participate in therapy?; How consistent are the messages that I communicate to clients related to their control within our relationship?; How and why am I being more active than the client in the therapy process?; How can I support clients in expressing their opinions, values, and sharing their experiences?; and, Am I valuing my knowledge as therapist over the clients'? This kind of mirror may not be flattering or easy to gaze into, but recognizing these features in other practice, as through this study, brings a sense of reality or normalcy to one's own practice. Self-reflection becomes less painful or shameful.

This process of reflection does not need to be only on the shortcomings of practice. This study can also serve to point out aspects of practice that are desirable in order to provide a vision of what one wishes to strive toward. The therapist's comfort in authentically presenting herself and her understanding of the members' experiences are but two examples of exemplary features of this practice that stand out for me.

The reflection provoked through this study's findings can go beyond direct clinical practice concerns. Although I did only intend to focus on the immediate experience of the group, larger significant issues could not be ignored. This study highlighted, for example, the often overlooked reality that occupational therapists do not work in professional

isolation. Dialogue with other disciplines is essential. This becomes even more critical in a medical model setting, where accepted assumptions often run contrary to a client-centred philosophy. Issues are especially magnified in treatment contexts such as this study's co-lead group. The need to advocate for truly collaborative involvement of the client becomes readily apparent through the experiences of the CLP group. It has been suggested that occupational therapists can be a catalyst for change in the entire health care system through their skill, example (Yerxa, 1994) and advocacy (CAOT, 1994). This suggestion might be only an ideality, however, this group experience does support the need for such change.

As the 21st century nears, forecasts in the professional literature are beginning to appear. It is predicted that the client-centred core of practice will remain (CAOT, 1994) but a need has been identified to increase the moral dimensions of the OT profession in order to make client-centred practice a reality (Brockett, 1993). Yerxa (1994) suggests that authentic OT will only happen once therapists take on the role of helping people become their own agents of competency and work toward removing social barriers to this. The ultimate goal of practice will be enablement of occupational competence (Polatajko, 1994). Understandings gained through this study and questions and issues raised have the potential to shift practice toward

this vision. The experiences presented through this study provide a challenge to all of us who have uncritically accepted current practice.

Theory

This exploration of a group experience also suggests potential significance to theory especially at the levels of explanatory theoretical models and concrete models of practice. One way in which the theory-practice gap revealed in this work may be explained is through suggesting that current theory is inadequate.

Theory was not an explicit part of the therapist's description of her experience of group. Her clinical reasoning seemed to be guided by tacit knowing developed through her experience. There is value in this, but it may not have been sufficient. The teaching-learning process, as an example of one aspect of the group practice, seemed valued by the therapist but rarely did she utilize it. Most participants' views of teaching in group emerged through their discussions of structured exercises. This traditional view of education as the teacher transmitting knowledge and skills to the student, however, has been radically challenged in the adult education literature (Brookfield, 1990; Candy, 1991; Cranton, 1992; Mezirow, 1985, 1990, 1991). This study indicates that there may be a need to

move beyond the present professional body of knowledge to appropriate other areas such as adult education, that are relevant and consistent with our philosophy and that complement current theory.

Attempts at guiding client-centred practice are becoming plentiful in the literature. Enhancing individual power (Kaplan, 1991; Delbanco, 1992; Matheis-Kraft et al, 1990; Sharf, 1988), minimizing loss of power (Gray et al., 1991), changing policies and procedures of health care agencies (Boumbulian et al., 1991), and incorporating principles of consumerism into practice (Bloomer, 1978) are discussed. The assessment process is often stressed (Jungerson, 1992; Law et al., 1991). Although the professional guidelines (CAOT, 1991, 1994) do much toward this aim, there seem to be continued needs. This study reiterates a fundamental need to advance the understanding of how to translate a client-centred philosophy to practice. Issues specific to group practice in particular, have yet to be addressed. Developing a collaborative relationship based on client values becomes especially difficult in groups. Focusing on the rights of the group may ignore the needs of each individual. Thus far, the concept of therapist-client relationship has been a focus of client-centred theory but Yalom (1983), for example, suggests that "cohesiveness" in group is analogous to "relationship" in individual therapy. This study's findings suggest a need to further explore

concepts such as cohesiveness that are directly relevant to group practice.

This study has clearly illustrated some of the complexities that need to be considered in the continued development of OT theory that will both enhance understanding and enhance application to practice.

Research

This study served to deepen the understanding of this group but as with its significance to practice, its value in terms of research may lie less in the questions answered than in the questions raised. I will discuss areas for further research precipitated by this study then will identify some of the issues that have emerged related to methodology.

Several possibilities for further research with the CLP group are apparent. The focus was on the point of intersection of the group and the lives of the participants for the brief time of data collection. Prolonged engagement could possibly enhance credibility (Lincoln & Guba, 1985) but could also deepen understanding. A longer term and wider exploration could reveal more the role of the group and its changing nature in the larger context of the participants' lives. A deeper understanding of the participants as people, and not merely in their roles as

leader and members of this group, could be valuable. A longer term involvement would also enable follow-up on themes raised (e.g., authority and control, reasoning guiding actions in group). Further research with a focus on the CLP group members could add to findings from current works such as understanding therapy from the life perspectives of the client (Crepeau, 1991) and more specifically, how members' experiences outside influence their experiences in therapy (Helfrich & Kielhofner, 1994). A focus on the therapist, a variable rarely addressed (HarPaz, 1994), could explore the influence of therapists's personality, values, and beliefs on approaches and outcomes. It could also be a fascinating process to follow through with this study's participants to better understand the implications of their involvement in this research project.

Additionally, further research could extend the understanding from this one group to other contexts (e.g., similar groups with different clients, sole lead and co-lead models, groups more or less structured, varied settings, and other areas of practice within and outside mental health). A multitude of topics are raised through this study: why people act and refrain from acting in the therapy context; therapists' clinical reasoning and clients' decision making; how people interact within the group and the therapy relationship and the effects of this interaction especially on equality and collaboration; co-leader/interdisciplinary

relationships; therapist and client understandings and how these are communicated; beneficial or positive factors of group (related to therapy, to activity, to learning); modifying group/therapy processes; and so forth. This study has vividly demonstrated part of the value of qualitative research in the abundance of issues that have emerged as potential areas of future research.

This study has responded to calls to explore the essence of client-centred practice, and in doing so, has revealed some specific aspects that warrant further investigation. It suggests a need to explore how therapists understand client experiences and knowledge and recognize what is relevant and purposeful to the client. A true therapist-client partnership seems to remain elusive and further investigation is needed to guide understanding of how to attain this, especially in group therapy. As was suggested in the discussion of the implications to theory, exploration of the concepts relevant or unique to group in addition to the client-therapist relationship may provide insights of significance to the group context. Closest in the current literature to addressing client centred features of groups is research on self-help or peer-support groups (Millsteed et al., 1991; Schultz, 1994). Comparing the experiences of groups with professional leadership, such as the CLP, to those withouth may serve to advance understanding. There is also a need to assess the influence

of the client-centred guidelines on OT practice. In the course of this research, the guidelines were only mentioned by the therapist when discussing the study's findings. Those most pertinent to the CLP group (i.e., CAOT, 1994), were only published mid-way through the research. How they may come to shape this group and other mental health practice could be explored.

The assumption that client centred is desirable also needs to continue to be challenged. There is a need to determine if improving the consistency and quality of client-centred practice alters outcomes that are relevant to clients. It is paradoxical that many of the issues that I have focussed on in my interpretations of the group experience were not raised by clients. It is easy to minimize the significance of this by labelling the clients' perceptions as perhaps being limited or distorted, but paradoxically, considerations that are client-centred may not always be consistent with the client's values and needs. There is a need to continue to explore the client's perspective to truly define the concept and its merits.

This study also highlights pragmatic and philosophical methodological issues of significance for future research. The OT profession is dealing with debate around technical versus practical interests, but this study opens this dialogue to considerations of emancipatory interests. Inherent are the moral issues of seeking practical without

emancipatory knowledge. The worth of understanding without action is especially cogent in a profession espousing a client-centred philosophy. These kinds of important philosophical questions related to the rightness or value of research paradigms are revealed, but what also emerges from this study are more pragmatic methodological issues when working within the interpretive or critical sciences.

I first became aware of one of these issues when obtaining consent. Fully informed consent was impossible because of the study's partially emergent design and inductive nature. At the time of consent, there was no way to predict outcomes or eventual methods of presenting findings. The option to withdraw would have been difficult to exercise once the study was underway, and especially difficult once data collection was complete. I initially saw this as less an issue because I aimed to involve participants as equals throughout the process. This lead to a pervasive theme related to true participant-researcher collaboration that repeatedly surfaced and warrants further consideration. How can a collaborative research relationship be fostered? How can people's communication of experience and reflection on their own experiences be facilitated? How does an outside researcher authentically enter others' lives? How can this happen without domination? These questions become especially germane when working with participants with little related experience and

skills. This is not a novel issue. Kincheloe (1991), for example, addresses it in his argument for the integration of teacher and researcher. This study suggests that consideration needs to continue to be extended.

The Group

Throughout the research process from the group's selection to the writing of the findings, I attempted to remain aware of implications to the leaders and members of this group. Although I did not explicitly aim toward emancipation, this study has the potential to serve as a moment in the participants' transformative process. In feedback I solicited from the participants, they did share that they enjoyed the experience of being involved in the research. For some, it provided a new way of looking at themselves; others discussed how it felt good to have had the opportunity to talk. Ideally, knowing that they have contributed to my learning may have enhanced participants' self-esteem, a key intermediary step between enlightenment and emancipation. I sought opportunities to acknowledge the contributions participants made. This seemed especially significant for the group members as the credibility and authority of individual with mental illness is often challenged (CAOT, 1994).

I speculate, though, that the main implication of this

study to the group was that it provided reflection opportunities for the leaders and members. This group was merely one piece of a job, of therapy, and of lives. The mandate of the clinic was service delivery, and in such environments, it is recognized that there is often little opportunity for reflection (Schon, 1987). As for the members of the group, their preoccupation with daily routines and issues could have lead to the perception that time for reflection and analysis is wasteful. Without the opportunity provided by their involvement in this research, it is likely that the group experience could have been lost in the tide of other life activities. Perhaps this involvement has allowed people to pause and pay attention. The more ideal parts of themselves and the group might be revealed so that participants can chose to work toward this ideal. Discrepancies with their previous experiences or their vision of the ideal may also be revealed. This in itself can be a powerful initiator of further reflection and change (Mezirow, 1990, 1991) and through gaining understanding and insight participants may be helped in gaining control (Lather, 1986a).

My concern in considering such implications is that these opportunities were initiated by me as researcher. Members were in the group, however, because they sought change, and participants did volunteer for the study, but none openly expressed these kinds of motives for being

involved in the study. Imposed reflection is unlikely to be of any great benefit. I hope that for some participants, that they will have claimed this process as their own.

The implications to the people involved in the group do not end with this work. I will return to the clinic and to the group to present these findings and to facilitate the process of making this study meaningful to all. I recognize that knowledge generated by research is not sufficient for action. I hope to share information in a sensitive and enabling manner so that this giving back may lead to joint decisions about appropriate courses of action. I also hope to join with some participants in the process of disseminating findings from this study.

Personal Implications

Above all, this research has been a personal process, the implications of which I will likely continue to recognize. This study has prepared me to be better able to act in clinical situations as a more reflective practitioner with increased sensitivity to the subtle and complex nature of client-centred practice. I am now also better able to interpret and undertake future research, and to understand, apply, and contribute to theory development.

At a more fundamental level, this study has engaged me

in a transformative journey. The extent of this transformation is best illustrated by recounting the conceptualization of this study. I had reached a point in my clinical career where as a therapist, I wanted to learn to be a better teacher. I viewed an academic setting as a necessity for serious learning, so I entered this path known as the Master of Education program.

The seeds of this study were born in what I now recognize as a positivistic rearing. My previous formal exposures to research were narrow. I recall well the lessons learned in an undergraduate research course--if a study is not a randomized controlled trial, it is not worth the time it takes to read it. I was anxious to plan my thesis research so I registered in the required research course as soon as I was able to. The course emphasized quantitative methods. I recall a discussion of historical research which sounded interesting but far too time consuming to merit serious consideration. Besides, I believed that real knowledge came from empirical studies. I decided to compare two or more educational techniques and expected that the results would surely tell me how best to teach. I began my foray into adult education to seek out these variables. I believed that they existed; I only needed to find them. Ripples of my exploration expanded from concurrent readings of early adult education theory and of educational approaches in health care to readings of

recent works in the adult education field, methods of inquiry, and current OT professional issues. My own learning flourished and this study evolved. It started as an objective comparison of techniques and ended as a subjective exploration of experience.

To borrow the words of Yerxa (1991) as she compared phenomenological to experimental research, the outcome of this study has been "less precise but more real" (p.201). The outcome has not only been more real but more meaningful. I continue to hold client-centred values close but no longer undiscerningly. I also continue to believe that an educational focus in groups promises great therapeutic potential but I have come to understand that education is much more than imparting packages of information and that there is value beyond technical knowing.

The personal implications extend beyond the issues of focus in this study. Throughout the process, my preconceptions have been challenged and I have become aware of some of the limitations. I am no longer so polarized in my thinking. I can tolerate and am intrigued by complexity. I have come to value other ways of knowing and am growing to trust my own tacit and intuitive knowledge. My confidence used to emanate from falsely believing that I knew correct answers; it now has grown despite my realization of not knowing.

I have come to realize that the Master of Education

program is not an end, but a part of a journey toward an unknown destination. My learning has not concluded. This is merely a natural point to pause in the process, to reflect before re-entering practice and then to continue the transformation. I have not answered my original question how best to teach; I have discarded it. This exploration of the client and therapist experiences of a mental health group has accomplished much more. It has induced in me a thirst for further inquiry. It has prepared me so that I will now be able to continue my learning from the teachers around and within me.

REFERENCES

Abramson, J. S. (1990). Enhancing patient participation: Clinical strategies in the discharge planning process. Social Work in Health Care, 14, 53-71.

Ager, C. (1986). Teaching strategies for the elderly. Physical and Occupational Therapy in Geriatrics, 4, 3-14.

Allen, V. R. (1986). Health promotion in the office. American Journal of Occupational Therapy, 40, 764-770.

American Occupational Therapy Association [AOTA]. (1993a). Core values and attitudes of occupational therapy practice. American Journal of Occupational Therapy, 47, 1085-1086.

American Occupational Therapy Association [AOTA]. (1993b). Occupational therapy roles. American Journal of Occupational Therapy, 47, 1087-1098.

Anderson, F., Funnell, M., Barr, M., Dedrick, E., & Davis, B. (1991). Learning to empower patients: Results of a professional education program for diabetes educators. Diabetes Care, 14, 584-590.

Antai-Otong, D. (1989). Concerns of the hospitalized and community psychiatric client. Patient Teaching, 24, 665-673.

Anthony, W. A., & Farkas, M. (1982). A client outcome planning model for assessing psychiatric rehabilitation interventions. Schizophrenia Bulletin, 8, 13-38.

Armstrong, M. L. (1989). Orchestrating the process of patient education, methods and approaches. Nursing Clinics of North America, 24, 597-604.

Ash, C. R. (1985). Applying principles of self-directed learning in the health professions. In S. Brookfield, (Ed.), Self-directed learning: From theory to practice [New Directions for Continuiing Education], (pp.63-73). San Francisco: Jossey-Bass.

Ascher-Svanum, H. (1989). A psychoeducational intervention for schizophrenic patients. Patient Education and Counseling, 14, 81-87.

Bakker, C. B., & Armstrong, H. E. (1976). The adult development program: An educational approach to the delivery of mental health services. Hospital and

Community Psychiatry, 27, 330-334.

Barney, K. (1991). Occupational therapy strategies to promote health with an expanding population of well elderly. Occupational Therapy Practice, 2, 69-81.

Barr, W.(1989). Teaching patients with life-threatening illnesses. Nursing Clinics of North America, 24, 639-644.

Barrett-Lennard, G. (1986). The client-centred system: A developmental perspective. In F. J. Turner, Social work treatment, (pp.181-238). New York: Free Press.

Bartlett, E. E. (1989). Whither patient-centred care? Patient Education and Counseling, 14, 97-99.

Barton, G., & Scheer, N. (1975). A measurement of attitudes about an activity program. American Journal of Occupational Therapy, 29, 284-287.

Bell, C, & Quintal, J. (1985). A life skills program for physically disabled adolescents. Canadian Journal of Occupational Therapy, 52, 235-239.

Bergum, V. (1991). Being a phenomonological researcher. In J. M. Morse, (Ed.), Qualitative nursing research: A contemporary dialogue (pp. 54-71). Newbury Park, CA: Sage Publications.

Bernard, F., & Therriault, P. (1986). Ergotherapie et education alimentaire. Canadian Jouurnal of Occupational Therapy, 53, 141-146.

Bernier, M. J. (1992). Current perspectives: Psychoedcuation: Subset or prototype of the health education model? Patient Education and Counseling, 19, 125-127.

Bloomer, J. S. (1978). The consumer of therapy in mental health. American Journal of Occupational Therapy, 32, 621-626.

Blumberg, B. D., & Gentry, E. D. (1991). Selecting a systematic approach for educating hospitalized cancer patients. Seminars in Oncology Nursing, 7, 112-117.

Bogden, R. C., & Biklen, S. K. (1992). Qualitative research for education: An introduction to theory and methods. Boston: Allyn and Bacon.

Boumbulian, P., MacGregor, W., Delbanco, T., Edgman-Levitan,

S., Smith, D., & Anderson, R. (1991). Patient-centred patient-valued care. Journal of Health Care for the Poor and Underserved, 2, 338-346.

Bowell, C., & Ashmore, A. (1992). The initiation and evaluation of a rheumatoid arthritis self-help group (RASH). British Journal of Occupational Therapy, 55, 21-24.

Bower, M. E. (1989). Self-regulation techniques in the elderly. Journal of Gerontological Nursing, 15, 15-20.

Boyd, M., Morris, M., Turner, M., & Little, J. (1991). For those left behind: An educational inpatient rehabilitation program. Journal of Psychosocial nursing, 29, 24-29.

Bradlee, L. (1984). The use of groups in short-term psychiatric settings. Occupational Therapy in Mental Health, 4, 47-57.

Brady, J. (1985). Social skills training for psychiatric patients. Occupational Therapy in Mental Health, 5, 59-74.

Breen, V. (1989). Education with activity: A health promotion program in a nursing home. Occupational Therapy in Health Care, 6, 101-111.

Bressler, S., & Jessome, P. (1993, June). Quality management - How well do we meet our users' needs? Paper presentation at the national conference of the Canadian Assocation of Occupational Therapists, Regina, Saskatchewan.

Brillhart, B., & Stewart, A. (1989). Education as the key to rehabilitation. Patient Teaching, 24, 675-679.

Brinberg, D., & Axelson, M. (1990). Increasing the consumption of dietary fiber: A decision theory analysis. Health Education Research, 5, 409-420.

Brink, P. J. (1991). Issues of relieability and validity. In J. M. Morse (Ed.). Qualitative nursing research: A contemporary dialogue (pp. 164-186). Newbury Park, CA: Sage.

Brockett, M. (1993, June). Building moral respect for clients in multicultural Canada. Roundtable discussion presented at the Canadian Association of Occupational Therapists' National Conference, Regina, Saskatchewan.

Brookfield, S. (1990). The skillful teacher. San Francisco: Jossey-Bass.

Brown, G. T., & Carmichael, K. (1992). Assertiveness training for clients with a psychiatric illness: A pilot study. British Journal of Occupational Therapy, 55, 137-140.

Bruce, M. A. & Borg, B. (1991). The group system: The therapeutic activity group in occupational therapy. Thorofare, NF: Slack.

Brundage, D. H., & MacKeracher, D. (1980). Adult learning principles and their application to program planning. Toronto: Ministry of Education.

Burgess, A., & Burns, J. (1990). Partners in care. American Journal of Nursing, 90, 73-75.

Burke, J. P. (1977). A clinical perspective on motivation: Pawn versus origin. American Journal of Occupational Therapy, 31, 254-279.

Butin, D. (1991). Helping those with dementia to live at home: An educational series. Physical and Occupational Therapy in Geriatrics, 9, 69-82.

Canadian Association of Occupational Therapists and Department of National Health and Welfare [CAOT & DNHW] (1983). Guidelines for the client-centred practice of occupational therapy (H39-33/1983E). Ottawa: Department of National Health and Welfare.

Canadian Association of Occupational Therapists and Department of National Health and Welfare [CAOT & DNHW] (1986). Intervention guidelines for the client-centred practice of occupational therapy (H39-100/1986E). Ottawa: Department of National Health and Welfare.

Canadian Association of Occupational Therapists and Department of National Health and Welfare [CAOT & DNHW] (1987). Toward outcome measure in occupational therapy (H39-114/1987E). Ottawa: Department of National Health and Welfare.

Canadian Association of Occupational Therapists [CAOT]. (1991). Occupational therapy guidelines for client-centred practice. Toronto: CAOT Publications ACE.

Canadian Association of Occupational Therapists [CAOT]. (1993). Guidelines for client-centred mental health practice. Toronto: CAOT Publications ACE.

Candy, P. C. (1991). Self-direction for lifelong learning: A comprehensive guide to theory and practice. San Francisco: Jossey-Bass.

Carkhuff, R., & Berenson, B. (1976). Teaching as treatment. Amherst, MA: HRD Press.

Carlton, R. (1987). The effects of body mechanics instruction on work performance. American Journal of Occupational Therapy, 41, 16-20.

Carmody T. P., Istvan, J., Matarazzo, J. D., Connor, S. L., & Connor, W. E. (1986). Application of social learning theory in the promotion of heart-healthy diets: The family heart study dietary intervention model. Health Education Research, 1, 13-27.

Carr, W., & Kemmis, S. (1986). Becoming critical: Education, knowledge and action research. London: The Falmer Press.

Carswell-Opzoomer, A. (1990). Occupational therapy: Our time has come. The Canadian Journal of Occupational Therapy, 57, 197-204.

Cartilage, P. (1984). Rheumatoid arthritis: A pilot evaluation of an inpatient education program. Australian Occupational Therapy Journal, 31, 14-19.

Carver, V., Kittleson, M., & Andrews, V. (1991). Assessing alcohol consumption attitudes of adolescent drinkers: Implications for alcohol education programs. Health Values, 15, 32-36.

Clark, F. (1993). Occupation embedded in real life: Interweaving occupational science and occupational therapy. American Journal of Occupational Therapy, 47, 1067-1078.

Cleary, M. (1992). Shame and shame-based syndromes: Implications for health education. Health Values, 16, 47-54.

Connors, M. E., Johnson, C. L., & Stuckey, M. K. (1984). Treatment of bulimia with brief psychoeducational group therapy. American Journal of Psychiatry, 141, 1512-1516.

Cranton, P. (1992). Working with adult learners. Toronto: Wall & Emerson.

Crepeau, E. (1991). Achieving intersubjective understanding: Examples from an occupational therapy treatment session. American Journal of Occupational Therapy, 45, 1016-1025.

Crist, P.H. (1986). Community living skills: A psychoeducational community-based program. Occupational Therapy in Mental Health, 6, 51-64.

Cunningham, A., & Tocco, E. (1989). A randomized trial of group psychoeducational therapy for cancer patients. Patient Education and Counseling, 14, 101-114.

Cunningham, B., & Kelsch, C. (1991). Patient and family teaching with the spinal cord-injured patient. Occupational Therapy Practice, 2, 31-39.

Daley, D., Bowler, K, & Cahalane, H. (1992). Approaches to patient and family education with affective disorders. Patient Eduation and Counseling, 19, 163-174.

Daltroy, L., & Liang, M. (1991). Advances in patient education in rheumatic disease. Annals of the Rheumatic Diseases, 50, 415-417.

Deegan, P. E. (1992). The independent living movement and people with psychiatric disabilities: Taking back control over our own lives. Psychosocial Rehabilitation Journal, 15, 3-19.

Deffenbacher, J., McNamara, K., Stark, R., & Sabadell, P. (1990). A comparison of cognitive-behavioral and process-oriented group counseling for general anger reduction. Journal of Counseling and Development, 69, 167-172.

Deffenbacher, J., & Stark, R. (1992). Relaxation and cognitve-relaxation treatments of general anger. Journal of Counseling Psychology, 39, 158-167.

Deffenbacher, J., Story, D., Stark, R., Hogg, J., & Brandon, A. (1987). Cognitive-relaxation and social skills interventions in the treatment of general anger. Journal of Counseling Psychology, 34, 171-176.

Delbanco, T. (1992). Enriching the doctor-patient relationship by inviting the patient's perspective. Annals of Internal Medicine, 116, 414-418.

DeMars, P. A. (1992). An occupational therapy life skills curriculum model for a native American tribe: A health promotion program based on ethnographic field research. American Journal of Occupational Therapy, 46, 727-736.

DeMuth, J. (1989). Patient teaching in the ambulatory setting. Nursing Clinics of North America, 24, 645-654.

DenBoer, D, Kok, G., Hospers, H., Gerards, F., & Strecher, V. (1991). Health education strategies for attributional retraining and self-efficacy improvement. Health Education Research, 6, 239-248.

Denton, P. (1982). Teaching interpersonal skills with videotape. Occupational Therapy in Mental Health, 2, 17-34.

Denton, P. (1987). Psychiatric occupational therapy: A workbook of practical skills. Boston: Little, Brown and Company.

DePoy, (1990). Mastery in clinical occuptional therapy. The American Journal of Occupational Therapy, 44, 415-422.

Devine, E. (1992). Effects of psychoeducational care for adult surgical patients: A meta-analysis of 191 studies. Patient Education and counseling, 19, 129-142.

Donovan, J. (1991). Patient education and the consultation: The importance of lay beliefs. Annals of the Rheumatic Diseases, 50, 418-421.

Donovan, J., Blake, D., & Fleming, W. (1989) The patient is not a blank sheet: Lay beliefs and their relevance to patient education. British Journal of Rheumatology, 28, 58-61.

Dortch, H., & Trombly, C. (1990). The effects of education on hand use with industrial workers. American Journal of Occupational Therapy, 44, 777-782.

Durbach, E., Goodall, R., & Wilkinson, K. (1987). Instructional objectives in patient eduation. Nursing Outlook, 35, 82-83,88.

Elias, W. S., & Murphy, R. J. (1986). The case for health promotion programs containing health care costs: A review of the literature. American Journal of Occupational Therapy, 40, 759-763.

Evert, M. M. (1993). Nationally speaking - Value in a changing environment. American Journal of Occupational Therapy, 47, 1063-1066.

Ewert, G. D. (1991). Habermas and education: A comprehensive overview of the influence of Habermas in educational literature. Review of Educational Research, 61, 345-378.

Fahrenfort, M. (1987). Patient emancipation by health education: An impossible goal? Patient Education and Counseling, 10, 25-37.

Falloon, I., & Talbot, R. (1982). Achieving the goals of day treatment. Journal of Nervous and Mental Disorders, 170, 279-282.

Falvo, D. R. (1985). Effective patient education: A guide to increased compliance. Rockville, MD: Aspen.

Field, P. A. (1991). Doing fieldwork in your own culture. In J. M. Morse, (Ed.), Qualitative nursing research: A contemporary dialogue (pp. 91-104). Newbury Park, CA: Sage.

Finlayson, M., & Edwards, J. (1992). Occupational therapy and health promotion: A natural partnership. Toronto: Canadian Association of Occupational Therapists Position Paper.

Fleming, M. (1991). The therapist with the three-track mind. American Journal of Occupational Therapy, 45, 1007-1014.

Fondiller, E., Rosage, L., & Neuhaus, B. (1990). Values influencing clinical reasoning in occupational therapy: An exploratory study. The Occupational Therapy Journal of Research, 10, 41-55.

Frankel, B. (1993). Groups for the chronic mental patient and the legacy of failure. International Journal of Group Psychotherapy, 43, 157-172.

Fraser, B., Finlayson, M., Letts, L., & Walls, J. (1993, June). Occupational therapy and health promotion. Workshop presented at the Canadian Association of Occupational Therapists National Conference, Regina, Saskatchewan.

Freire, P. (1972). Pedagogy of the oppressed. Harmondsworth: Penguin.

Furst, G. P., Gerber, L. H., Smith, C. C., Fisher, S., & Schulman, B. (1987). A program for improving energy conservation behaviors in adults with rheumatoid arthritis. American Journal of Occupational Therapy, 41, 102-111.

Garside, R. (1993a). From a consumer/survivor. Hamilton, ON: P.T. Publishing.

Garside, R. (1993b). From a consumer/survivor and occupational therapist. Hamilton, ON: P.T. Publishing.

Gessner, B. A. (1989). Adult education: The cornerstone of patient teaching. Nursing Clinics of North America, 24, 589-595.

Gilfoyle, E. (1984). Eleanor Clarke Slagle Lectureship, 1984: Transformation of a profession. American Journal of Occupational Therapy, 38, 575-584.

Gill, T., & Brockett, M. (1987). The national perspective - The guidelines for the client-centred practice of occupational therapy: The basis for practice in Canada. Canadian Journal of Occupational Therapy, 54, 53-54.

Giloth, B. (1990a). Management of patient education in US hospitals: Evolution of a concept. Patient Education and Counseling, 15, 101-111.

Giloth, B. (1990b). Promoting patient involvement: Educational, organizational, and environmental strategies. Patient Education and Counseling, 15, 29-38.

Giorgi, A. (Ed.). (1985). Phenomenology and psychological research. Pittsburgh: Duquesne University Press

Gingerich, E., Golden, S., Holley, D. Nemser, J., Nuzzola, P., & Pollen, L. (1992). The therapist as psychoeducator. Hospital and Community Psychiatry, 43, 928-930.

Glanz, K., Lewis, F.M., & Rimer, B.K. (Eds.). (1990) Health behavior and health education: Theory, research, and practice. San Francisco: Jossey-Boss Publishers.

Goldman C. R. (1988). Toward a definition of psychoeducation. Hospital and Community Psychiatry, 39, 666-668.

Goldstein, A. P., Gershaw, N. J., & Sprafkin, R. P. (1979). Structured learning therapy: Development and evaluation. American Journal of Occupational Therapy, 33, 635-639.

Goodwin-Johansson, C. (1988). Educating the adult patient. Lifelong learning, 11, 10-13.

Gould, R. (1990). The therapeutic learning program. In J. Mezirow (ed.), Fostering critical reflection in adulthood, (pp. 134-156). San Francisco: Jossey-Bass.

Gray, R., & Doan, B. (1990). Empowerment and persons with cancer: Politics in cancer medicine. Journal of Palliative Care, 6, 33-45.

Gray, R., Doan, B., & Church, K. (1991). Empowerment issues in cancer. Health Values, 15, 22-28.

Greenberg, L, Fine, S. B., Cohen, C., Larson, K., Michalson-Baily, A., Rubenton, P., & Glick, I. D. (1988). An interdisciplinary psychoeducation program for schizophrenic patients and their families in an acute care setting. Hospital and Community Psychiatry, 39, 277-282.

Griffin, W., Ling, I, & Staley, D. (1985). Stress management groups: The teaching and the benefits of group relaxation training in a psychiatric outpatient setting. Journal of Psychosocial Nursing, 23, 31-35.

Griswold, L. A. S. (1994). Ethnographic analysis: A study of classroom environments. American Journal of Occupational Therapy, 48, 397-402.

Grogan, G. (1991). Anger management: A perspective for occupational therapy (Part 1). Occupational Therapy in Mental Health, 11, 135-171.

Guba, E. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. Educational Resources Information Center Annual Review Paper, 29, 75-91.

Gusich, R., & Silverman, A. L. (1991). Basava day clinic: The model of human occupational as applied to psychiatric day hospitalization. Occupational Therapy in Mental Health, 11, 113-134.

Hansen, R. (1988). Nationally speaking - Ethics is the issue. American Journal of Occupational Therapy, 42, 279-281.

HarPaz, N. (1994). Failures in group psychotherapy: The therapist variable. International Journal of Group Psychotherpay, 44, 3-19.

Harries, P., & Cann, A. W. (1994). What do psychiatric inpatients and ward staff think about occupational therapy? British Journal of Occupational Therapy, 57, 219-223.

Hartley, L.KA. (1988). Congruence between teaching and learning self-care: A pilot study. Nursing Science Quarterly, 1, 161-167.

Hasselkus, B. (1989). The meaning of daily activity in family caregiving for the elderly. American Journal of Occupational Therapy, 43, 649-656.

Hasselkus, B. (1988). Meaning in family caregiving: Perspectives on caregiver/professional relationships. Gerontologist, 29, 686-691.

Hasselkus, B. (1983). Patient education and the elderly. Physical and Occupational Therapy in Geriatrics, 2, 55-70.

Hasselkus, B., & Dickie, V. (1990). Themes of meaning: Occupationa therapists' perspectives on practice. Occupational Therapy Jouranl of Research, 10, 195-207.

Hatfield, A. (1986). Semantic barriers to family and professional collaboration. Schizophrenia Bulletin, 12, 325-333.

Hayes, R., & Halford, W. K. (1993). Generalization of occupational therapy effects in psychiatric rehabilitation. American Journal of Occupational Therapy, 47, 161-167.

Hayes, R., Halford, W. K., & Varghese, F. (1991). Generalization of the effects of activity therapy and social skills training on the social behavior of low functioning schizophrenic patients. Occupational Therapy in Mental Health, 11, 3-20.

Hayman, S. (1993). The client-centred approach and activity selection in psychosocial OT: An exploratory study. Unpublished master's thesis, University of Western Ontario, London.

Health and Welfare Canada. (1988). Mental health for Canadians: Striking a balance. Ottawa: Government of Canada.

Healy, M. L. (1991). Guided fantasy: A method for teaching coping skills to the young child with juvenile rheumatoid arthritis. Occupational Therapy Practice, 2, 40-50.

Healy, H., & Woodhouse, J. (1993, June). The missing link: The Canadian occupational performance measure and goal implementation with adolescents. Paper presented at the Canadian Association of Occupational Therapists national conference, Regina, Saskatchewan.

Helfrich, C., & Kielhofner, G. (1994). Volitional narratives and the meaning of therapy. American Journal of Occupational Therapy, 48, 319-324.

Henbest, R., & Fehrsen, G. (1992). Patient-centredness: Is it applicable outside the west? Its measurement and effect on outcomes. Family Practice, 9, 311-317.

Heras, G. de las, Dion, G., & Walsh, D. (1993). Application of rehabilitation models in a state psychiatric hospital. Occupational Therapy in Mental Health, 12, 1-32.

Herring, C. L. (1989). Education for and being educated by the well elderly. Occupational Therapy in Health Care, 6, 125-133.

Hinojosa, J. (1990). How mothers of preschool children with cerebral palsy perceive occupational and physical therapists and their influence on family life. Occupational Therapy Journal of Research, 10, 145-162.

Holloway, E. (1994). Parent and occupational therapist collaboration in the neonatal intensive care unit. American Journal of Occupational Therapy, 48, 535-538.

Jaffe, E. (1989). Medical consumer education: Health promotion in the workplace. Occupational Therapy in Health Care, 5, 5-26.

Jaffe, E. (1986). The role of occupational therapy in disease prevention and health promotion. American Journal of Occupational Therapy, 40, 749-752.

Jenny, J. (1990). Nursing patient education: A Canadian perspective. Patient Education and Counseling, 16, 47-52.

Johnson, J. A. (1986). Wellness and occupational therapy. American Journal of Occupational Therapy, 40, 758-753.

Johnson, M. (1987). Occupational therapists and the teaching of cognitive behavioral skills. Occupational Therapy in Mental Health, 7, 69-81.

Jungerson, K. (1992). Culture, theory, and the practice of occupational therapy in New Zealand/Aotearoa. American Journal of Occupational Therapy, 46, 745-750.

Kaplan, S., & Burch-Minakan, L. (1986). Reach out for health: A corporation's approach to health promotion. American Journal of Occupational Therapy, 40, 777-780.

Kaplan, K. (1986). The directive group: Short-term treatment for psychiatric patients with a minimal level of functioning. American Journal of Occupational Therapy, 40, 474-481.

Kaplan, R. M. (1991). Health-related quality of life in patient decision making. Journal of Social Issues, 47, 69-90.

Kaplan, S. H. (1985). Patient education techniques used at burn centers. American Journal of Occupational Therapy, 39, 655-658.

Kaplan, S. H., Greenfield, S., & Ware, J. E. (1989). Assessing the effects of physician-patient interactions on the outcomes of chronic disease. Medical Care, 27, 110-127.

Kasch, C., & Knutson, K. (1985). Patient compliance and interpersonal style: Implications for practice and research. Nurse Practitioner, 10, 52-54.

Kautzmann, L. N. (1991). Facilitating adult learning in occupational therapy patient education programs. Occupational Therapy Practice, 2, 1-11.

Kielhofner, G. (1981). An ethnographic study of deinstitutionalized adults: Their community settings and daily life experiences. Occupational Therapy Journal of Research, 1, 125-142.

Kielhofner, G. (1982a). Qualitative research: Part one: Paradigmatic grounds and issues of reliability and validity. Occupational Therapy Journal of Research, 2, 67-79.

Kielhofner, G. (1982b). Qualitative research: Part two: Methodological approaches and relevance to occupational therapy. Occupational Therapy Journal of Research, 2, 150-164.

Kielhofner, G. (ed.). (1985). A model of human occupation: Theory and application. Baltimore: Willliams & Wilkins.

Kielhofner, G., & Nelson, C. (1983). A study of patient motivation and cooperation/participation in occupational therapy. Occupational Therapy Journal of Research, 3, 35-49.

Kincheloe, J. L. (1991). Teachers as researchers: Qualitative inquiry as a path to empowerment. London: The Falmer Press.

King, L. (1978). Occupational therapy research in psychiatry. American Journal of Occupational Therapy, 32, 15-18.

King, P. (1993). A program planning model for injury prevention education. Occupational Therapy Practice, 4, 47-53.

Kirk, J., & Miller, M. (1986). Reliability and validity in qualitative research. Beverly Hills, CA: Sage.

Kok, G., deVries, H., Mudde, A., & Strecher, V. (1991). Planned health education and the role of self-efficacy: Dutch research. Health Education Research, 6, 231-238.

Krefting, L. (1989a). Disability ethnography: A methodological approach for occupational therapy research. The Canadian Journal of Occupational Therapy, 56, 61-66.

Krefting, L. (1989b). Reinitegration in to the community after head injury: The results of an ethnographic study. Occupational Therapy Journal of Research, 9, 67-83.

Lalonde, M. (1974). A new perspective on the health of Canadians. Ottawa, ON: Department of National Health and Welfare.

Lather, P. (1986a). Issues of validity in openly ideological research: Between a rock and a soft place. Interchange, 17, 63-84.

Lather, P. (1986b). Research as praxis. Harvard Educational Review, 56, 257-277.

Law, M, Baptiste, S., Carswell-Opzoomer, A, McColl, M. A., Polatajko, H., & Pollock, N. (1991). Canadian occupational performance measure. Toronto: CAOT Publications ACE.

Law, M. Baptiste, S., & Mills, J. (1993, June). Issues in client-centerd practice. Paper presented at the Canadian Association of Occupational Therapists' National

Conference, Regina, Saskatchewan.

Law, M., & Pollock, N. (1993, June). The Canadian Occupational Performance Measure. Workshop presented at the Canadian Association of Occupational Therapists' National Conference, Regina, Saskatchewan.

Lillie, M., & Armstrong, H. (1982). Contributions to the development of psychoeducational approaches to mental health service. American Journal of Occupational Therapy, 36, 438-443.

Lincoln, Y., & Guba, E. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage.

Lipetz, M., Bussigel, M., Bannerman, J., & Risley, B. (1990). What is wrong with patient education programs? Nursing Outlook, 38, 184-190.

Lipson, J. G. (1991). The use of self in ethnographic reserach. In J. M. Morse, (Ed.), Qualitative nursing research: A contemporary dialogue (pp. 73-89). Newbury Park, CA: Sage.

Lloyd, C., & Maas, F. (1993). The helping relationship: The application of Carkuff's model. Canadian Journal of Occupational Therapy, 60, 83-89.

Luker, K., & Caress, A. (1989). Rethinking patient education. Journal of Advanced Nursing, 14, 711-718.

Lynch, C. (1986). National implementation of a parent education program. World Federation of Occupational Therapists Bulletin, 14, 21-23.

Lysack, C., Krefting, L., Stadynk, R., Paterson, M., & Harvey, C. (1993, June). Implications for community based occupational therapy: The results of a study using a survey approach. Paper presented at the Canadian Association of Occupational Therapists' National Conference, Regina, Saskatchewan.

Mann, W., & McKinley, J. (1991). Preparation of persons with cognitive disabilities for employment: Learning keyboarding skills. Occupational Therapy Practice, 2, 51-61.

Marken, D. M. (1991). Individuals with developmental disabilities learn to use the public library. Occupational Therapy Practice, 2, 62-68.

Martin, J. (1991). Occupational therapy in bulimia. British Journal of Occupational Therapy, 54, 48-52.

Matheis-Kraft, C., George, S., Olinger, M., & York, L. (1990). Patient-driven healthcare works! Nursing Management, 21, 124-128.

Mauras-Corsino, E, Daniewicz, F., & Swan, S. (1985). The use of community networks for chronic psychiatric patients. American Journal of Occupational Therapy, 39, 374-378.

Maycock, J. (1991). Role of health professionals in patient education. Annals of the Rheumatic Diseases, 50, 429-434.

Maxmen, J. (1973). Group therapy as viewed by hospital patients. Archives of General Psychiatry, 28, 404-408.

McAvoy, E. (1992). Occupational who? Never heard of them! An audit of patient awareness of occupational therapists. British Journal of Occupational Therapy, 55, 229-232.

McCain, N., & Lynn, M. (1990). Meta-analysis of a narrative review studies evaluating patient teaching. Western Journal of Nursing Research, 12, 347-358.

McDougall, S. (1992). The effect of nutritional education on the shopping and eating habits of a small group of chronic schizophrenic patients living in the community. British Journal of Occupational Therapy, 55, 62-68.

Meara, N., & Schmidt, L. (1991). The ethics of researching counseling and therapy processes. In C. Watkins & L. Schneider, (Eds.), Research in counseling (pp.237-259). Hillsdale, NJ: Lawrence Erlbaum Associates.

Meisenheimer, C. (1991). The consumer: Silent or intimate player in the quality revolution. Holistic Nursing Practice, 5, 39-50.

Mellenthin-Seeman, U. (1987). A patient education programme. World Federation of Occupational Therapists Bulletin, 15, 8.

Merriam, S. B. (1988). Case study research in education: A qualitative approach. San Francisco: Jossey-Bass Publishers.

Meyer, A. (1922). The philosophy of occupational therapy. Archives of Occupational Therapy, 1, 1-10.

Mezirow, J. (1985). A critical theory of self-directed learning. In S. Brookfield (Ed.), Self-directed learning: From theory to practice. New Directions for Continuing Education, no. 25. San Francisco: Jossey-Bass.

Mezirow, J. (1990). Fostering critical reflection in adulthood. San Francisco: Jossey-Bass.

Mezirow, J. (1991). Transformative dimensions of adult learning. San Francisco: Jossey-Bass.

Miles, M.B., & Huberman, A. M. (1994). Qualitative data analysis (2nd ed.). Thousand Oaks, CA: Sage.

Millsteed, J., Wallace, S., & McIntosh, W. (1991). Self-help for women with bulimia and anorexia nervosa. World Federation of Occupational Therapist Bulletin, 23, 2-6.

Mocellin, G. (1992a). An overview of occupational therapy in the context of the American influence on the profession: Part 1. British Journal of Occupational Therapy, 55, 7-12.

Mocellin, G. (1992b). An overview of occupational therapy in the context of the American influence on the profession: Part 2. British Journal of Occupational Therapy, 55, 55-60.

Mohr, W. K. (1993). Nurse-led educational program in psychiatric settings: Developing a curriculum. Journal of Psychosocial Nursing, 31, 34-38,46.

Morse, J. M. (Ed.). (1991a). Qualitative nursing research: A contemporary dialogue. Newbury Park, CA: Sage Publications.

Mosey, A. C. (1981). Occupational therapy: Configuration of a profession. New York: Raven Press.

Moustakas, C. (1990). Heuristic reserach: Design, methodology, and applications. Newbury Park, CA: Sage Publications.

Mungai, A. (1985). The occupational therapist's role in employee health promotion programs. Occupational Therapy in Health Care, 2, 67-78.

Nelson, C., & Payton, O. (1991). A system for involving patients in program planning. American Journal of Occupational Therapy, 45, 753-755.

Nemec, P., McNamara, S., & Walsh, D. (1992). Direct skills teaching. Psychosocial Rehabilitation Journal, 16, 13-25.

Neville-Jan, A., Bradley, M., Bunn, C., & Gehri, B. (1991). The model of human occupation and individuals with co-dependency problems. Occupational Therapy in Mental Health, 11, 73-97.

Nickel, I. (1988). Adapting structured learning therapy for use in a psychiatric adult day hospital. Canadian Journal of Occupational Therapy, 55, 21-25.

Noble, C. (1991). Are nurses good patient educators? Journal of Advanced Nursing, 16, 1185-1189.

Oberst, M. (1989). Nursing Clinics of North America, 24, 621-627.

O'Kelly, J. G., & Azim, H. F. (1993). Staff-staff relations group. International Journal of Group Psychotherapy, 43, 469-483.

Ottenbacher, K. (1992). Nationally speaking: Confusion in occupational therapy research: Does the end justify the method? American Journal of Occupational Therapy, 46, 871-874.

Padberg, R., & Padberg, L. (1990). Strengthening the effectiveness of patient education: Applying priniciples of adult education. Oncology Nursing Forum, 17, 65-69.

Padilla, G. V., & Bulcavage, L. M. (1991). Theories used in patient/health education. Seminars in Oncology Nursing, 7, 87-96.

Palmer, M. L., & Toms, J. E. (1986). Manual for functional training. Philadelphia: F.A. Davis Company.

Parham, D. (1987). Toward professionalism: The reflective therapist. The American Journal of Occupational Therapy, 41, 555-561.

Patton, M. Q. (1990). Qualitative evaluation and research methods. Newbury Park, CA: Sage.

Peloquin, S. (1990). The patient-therapist relationship in occupational therapy: Understanding visions and images. American Journal of Occupational Therapy, 44, 13-21.

Peloquin, S. (1993a). The depersonalization of patients: A profile gleaned from narratives. American Journal of Occupational Therapy, 47, 830-837.

Peloquin, S. (1993b). The patient-therapist relationship: Beliefs that shape care. American Journal of Occupational Therapy, 47, 935-942.

Polatajko, H. J. (1994). Dreams, dilemmas, and decisions for occupational therapy practice in a new millennium: A Canadian perspective. American Journal of Occupational Therapy, 48, 590-594.

Polimeni-Walker, I., Wilson, K. G., & Jewers, R. (1992). Reasons for participating in occupational therapy groups: Perceptions of adult psychiatric inpatients and occupational therapists. Canadian Journal of Occupational Therapy, 59, 240-247.

Pollack, N. (1993). Client-centred assessment. American Journal of Occupational Therapy, 47, 298-301.

Quirk, M., & Wapner, S. (1991). Notes on an organismic-developmental, systems perspective for health education. Health Education Research, 6, 203-210.

Radomski, M., & Dougherty, P. (1991). From the editors - Patient education. Occupational Therapy Practice, 2, iv.

Raskin, N. J., & Rogers, C. R. (1989). Person-centered therapy. In R. J. Corsini & D. Wedding (Eds.), Current psychotherapies (pp.154-194). Itasca, IL: F. E. Peacock.

Redman, B. K. (1993). The process of patient teaching in nursing (4th ed.). St. Louis: The C. V. Mosby Company.

Redman, Barbara K. (1981). Issues and concepts in patient education. New York: Appleton-Century-Crofts.

Reed, K. L. (1984). Models of practice in occupational therapy. Baltimore: Williams & Wilkins.

Reitz, S. M. (1992). A historical review of occupational therapy's role in preventive health and wellness. American Journal of Occupational Therapy, 46, 50-55.

Rider, B., & White, V. (1986). Occupational therapy education in health promotion and disease prevention. American Journal of Occupational Therapy, 40, 781-783.

Roback, H., Ochoa, E., Bloch, F., & Purdon, S. (1993). Guarding confidentiality in clinical groups: The therapist's dilemma. International Journal of Group Psychotherapy, 43, 81-103.

Rogers, C. R. (1951). Client-centred therapy. Boston: Houghton Mifflin.

Rogers, C. R. (1969). Freedom to learn. Columbus, OH: Merrill.

Rogers, C. R. (1983). Freedom to learn for the 80's. Columbus, OH: Charles E. Merrill.

Rogers, J., & Masaganti, G. (1982). Clinical reasoning of occupational therapists during the initial assessment of physically disabled patients. Occupational Therapy Journal of Research, 2, 193-219.

Rosenstock, I., Strecher, V., & Becker, M. (1988). Social learning theory and the health belief model. Health Education Quarterly, 15, 175-183.

Rotert, D. (1993). Occupational therapy in alcoholism. Occupational Therapy Practice, 4, 1-11.

Royeen, C. B. (1988). A humanist's approach to research, In C. B. Royeen (Ed.), Research traditions in occupational therapy: Process, philosophy, and status (pp.25-37). Thorofare, NJ: Slack.

Ruzicki, D. (1990). Promoting patient self-management in the health care system. Patient Education and Counseling, 15, 1-2.

Schon, D. A. (1987). Educating the reflective practitioner: Toward a new design for teaching and learning in the professions. San Francisco: Jossey-Bass.

Schultz, C. H. (1994). Helping factors in a peer-developed support group for persons with head injury, Part 2: Survivor interview perspective. American Journal of Occupational Therpay, 48, 305-309.

Schwartz, K. B. (1990). Creating excellence in patient care. American Journal of Occupational Therapy, 44, 816-821.

Schwartz, K. B. (1992). Occupational therapy and education: A shared vision. American Journal of Occupational Therapy, 46, 12-18.

Schwartz, R. (1989). Cognition and learning in industrial accident injury prevention. Occupational Therapy in Health Care, 6, 67-85.

Schwartz, R. K. (1991b). Educational and training strategies: Therapy as learning. In C. Christiansen & C. Baum (Eds.), Occupational therapy: Overcoming human performance defecits (pp.664-698). Thorofare, NJ: Slack.

Schwartz, R. K. (1985). Therapy as learning. Dubuque, Iowa: Kendall/Hunt.

Schwartzberg, S. (1994). Helping factors in a peer-developed support group for persons with head injury, Part 1: Participant observer perspective. American Journal of Occupational Therapy, 48, 297-304.

Seidel, J., & Clark, J. (1984). The ethnograph: A computer program for the analysis of qualitative data. Qualitative Sociology, 7, 110-125.

Seidman, I. (1991). Interviewing as qualitative research. New York: Teachers College Press.

Serrett, K. D. (1985a). Another look at occupational therapy's history: Paradigm or pair-of-hands. Occupational Therapy in Mental Health, 5, 1-31.

Serrett, K. D. (1985b). Eleanor Clarke Slagel: Founder and leader in occupational therapy. Occupational Therapy in Mental Health, 5, 101-108.

Sharf, B. (1988). Teaching patients to speak up: Past and future trends. Patient Education and Counseling, 11, 95-108.

Short-DeGraff, M., & Fisher, A. (1993). Nationally Speaking - A proposal for diverse research methods and a common research language. American Journal of Occupational Therapy, 47, 295-297.

Shotwell, S. (1991). Occupational therapy practice: Practice dilemma. Occupational Therapy Practice, 2, 82-87.

Simons-Morton, D., Mullen, P., Mains, D., Tabak, E., & Green, L. (1992). Characteristics of controlled studies of patient education and counseling for preventive health behaviors. Patient Education and Counseling, 19, 175-204.

Smith, C. (1989). Overview of patient education: Opportunities and challenges for the twenty-first century. Nursing Clinics of North America, 241, 583-587.

Smith, A. R., & Tempone, V. J. (1968). Psychiatric occupational therapy within a learning theory context. American Journal of Occupational Therapy, 22, 415-425.

Spencer, J., Krefting, L., & Mattingly, C. (1993). Incorporation of ethnographic methods in occupational therapy assessment. The American Journal of Occupational Therapy, 47, 303-309.

Stein, F., & Nikolic, S. (1989). Teaching stress management techniques to a schizophrenic patient. The American Journal of Occupational Therapy, 43, 162-169.

Stein, F., & Smith, J. (1989). Short-term stress management programme with acutely depressed in-patients. Canadian Journal of Occupational Therapy, 56, 185-192.

Stern, P. A. S. (1991a). Patient education in a research/clinical setting: The schizophrenia research unit. Occupational Therapy Practice, 2, 21-30.

Stern, P. N. (1991b). Are counting and coding a cappella appropriate in qualitative research? In J. M. Morse, (Ed.), Qualitative nursing research: A contemporary dialogue (pp. 147-162). Newbury Park, CA: Sage.

Stern, M., & Restall, G. (1993, June). Client-centred practice and the medical model: A peaceful co-existence or sibling rivalry? Roundtable discussion at the Canadian Association of Occupational Therapists' National Conference, Regina, Saskatchewan.

Stewart, A. (1994). Empowerment and enablement: Occupational therapy 2001. British Journal of Occupational Therapy, 57, 248-254.

Stoffel, V. C., & Cunningham, S. M. (1991). Continuous quality improvement: An innovative approach applied to mental health programs in occuptional therapy. Occupational Therapy Practice, 2, 52-60.

Strong, J., Ashton, R., Chant, D., & Cramond, T. (1994). An investigation of the dimensions of chronic low back pain: The patients' perspectives. British Journal of Occupational Therapy, 57, 204-208.

Sumsion, T. (1993). Client-centred practice: The true impact. Canadian Journal of Occupational Therapy, 60, 6-8.

Taylor, E. (1988). Anger intervention. American Journal of Occupational Therapy, 42, 147-155.

Townsend, L., & Banks, S. (1992). Exploring client-centred practice. National (Candian Association of Occupational Therapy), 9 (5).

Townsend, E., Britnell, S., & Staisey, N. (1990). Developing guidelines for client-centred occupational therapy practice. Canadian Journal of Occupational Therapy, 57, 69-76.

Tryssenaar, J., & Hopkins, L.M. (1993, June). The client as co-leader: A valuable resource. Paper presented at the Canadian Association of Occupational Therapists' National Conference, Regina, Saskatchewan.

Tryssenaar, J, Huddart, C., & Babiski, L. (1993, June). Client choice: Therapist responsibilty. Roundtable discussion at the Canadian Association of Occupational Therapists national conference, Regina, Saskatchewan.

Vergeer, G., & MacRae, A. (1993). Therapeutic use of humor in occupational therapy. American Journal of Occupational Therapy, 47, 678-683.

Wallace,C., Nelson, C., Liberman, R., Aitchison, R., Lukoff, D., Elder, J., & Ferris, C. (1980). A review and critique of social skills training with schizophrenic patients. Schizophrenia Bulletin, 61, 42-63.

Wallach, W. (1988). Incorporating structured learning therapy into OT treatment. Occupational Therapy in Health Care, 5, 141-148.

Wallerstein, N., & Bernstein, E. (1988). Empowerment education: Freire's ideas adapted to health education. Health Eduation Quarterly, 15, 379-394.

Walsh, J. (1992). Methods of psychoeducational program evaluation in mental health settings. Patient Education and Counseling, 19, 205-218.

Webster, D., & Schwartzberg, S. (1992). Patients' perception of curative factors in occupational therapy groups. Occupational Therapy in Mental Health, 12, 3-24.

Wilson-Barrett, J. (1988). Patient teaching or patient counselling? Journal of Advanced Nursing, 13, 215-222.

Woodside, H. (1991). The participation of mental health consumers in health care issues. Canadian Journal of Occupational Therapy, 58, 3-5.

Yalom, I. D. (1985) The theory and practice of group psychotherapy (3rd ed.). New York: Basic Books.

Yalom, I. D. (1983). Inpatient group psychotherapy. New York: Basic Books.

Yerxa, E. (1991). Nationally speaking -- Seeking a relevant, ethical, and realistic way of knowing for occupational therpy. American Journal of Occupational Therapy, 45, 199-204.

Yerxa, E. (1994). Dreams, dilemmas, and decisions for occupational therpay practice in a new millennium: An American perspective. American Journal of Occupational Therapy, 48, 586-589.

Yoder Wise, P. (1979). Barriers (or enhancers) to adult patient education. The Journal of Continuing Education in Nursing, 10, 11-16.

Young, G. (1991). Energy conservation, occupational therapy, and the treatment of post-polio sequelae. Orthopedics, 14, 1233-1239.

Young Women's Christian Association [YWCA]. (1986). Discovering life skills with special needs groups, volume IV. Toronto: YWCA.

Appendix A

Definition of Terms

Client

Client is a general term to describe the recipient of OT services (CAOT, 1991). The client may be an individual, group, or system. In this study, it is used to refer to the individual recipient of any health care service. In common usage, it is often replaced by words that more accurately describe where the client receives services (i.e., patient, resident, or consumer). The term is not fully accepted either by consumer groups or by health professions, but it has been selected as the most consistent term with this proposed study's client-centred frame of reference.

Client Centred

The term client centred refers to an approach, method, or philosophy that originated in the works of Carl Rogers. It was formally adopted by the OT profession in Canada in the mid 1980s (CAOT & DNHW, 1983, 1984, 1985). There is not yet any commonly agreed upon definition of the term. For the purpose of this study, client-centred, at its most basic form, involves a shared collaborative relationship in which the client values direct the therapy process.

Client Education

Client education, used essentially as a synonym for patient education because it is more consistent with the study's frame of reference, refers to employing the teaching-learning process in the context of a health professional-client context.

Community Living Planning (CLP) Group

The CLP is the focus of this exploration of the experiences of group. It is an ongoing group of up to 12 members who meet once weekly at a community mental health clinic. Its primary purpose is to support and assist its members through the process of setting goals. It is co-lead by an occupational therapist and nurse. Further details are provided in chapters five and six, and in appendix B.

Education Groups or Educationally-Oriented Groups

Education groups are a common format for providing client education in health care, and especially in mental health. Educational aims may be either explicit or implicit.

Empowerment

Empowerment may be defined as "a social action process that promotes participation of people, organizations, and communities in gaining control over their lives in their community and the larger society....[it] is not characterized as achieving power to dominate others, but rather power to act with others to effect change" (Wallerstein & Bernstein, 1988, p.380).

Enablement

Enablement is "an educational process which ... helps people to learn about themselves and their situation, and about their ability to make decisions which fulfil their sense of purpose in life" (CAOT, 1994, p.80).

Function

Function refers to "the skill to perform activities in a normal or accepted ways and/or adequately for the required tasks of a specific role or setting" (CAOT, 1994, p.80).

Goal

A goal is "the purpose or aim of a client's program, which determines the client's and the occupational therapist's activities" (CAOT, 1994, p.80).

Group

"A group is an aggregate of people who share a common purpose which can be attained only by group members interacting and working together" (Mosey in Howe & Schwartzberg, 1980, p.5). Group is a commonly used therapeutic modality in occupational therapy, and is the focus of this study.

Health Education

Health education has the widely accepted purposes of preventing disease, enhancing health, managing chronic illness, and/or improving well-being (Glanz, Lewis & Rimer, 1990). At times it is used synonymously with patient education, however, it is usually less medicalized and often refers to education occurring in a community not health care settings.

Leader

Leader, as used in this study, refers to the person, usually a health care professional, who directs or facilitates a group.

Learning (Adult)

"Adult learning refers both to the process which individuals go through as they attempt to change or enrich their knowledge, values, skills, or strategies and to the resulting knowledge, values, skills, strategies and behaviour possessed by each individual" (Brundage & MacKeracher, 1980, p.5).

Leisure

Leisure encompasses "the components of life which are free from work and self-care activities" (CAOT, 1994, p.81).

Member

Member, as used in this study, refers to a client participating in a therapy group.

Mental Disorder

"A mental disorder may be defined as a recognized, medically diagnosable illness that results in the significant impairment of an individual's cognitive, affective or relational abilities. Mental disorders result from biological, developmental and/or psychosocial factors..." (Health and Welfare Canada, 1988, p.8).

Mental Health

"Mental health is the capacity of the individual, the group and the environment to interact with one another in ways that promote subjective well-being, the optimal development and use of mental abilities, the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equality" (Health & Welfare Canada, 1988, p.7).

Occupational Performance

Occupational performance is a concept which refers to "activities carried out by the client in the areas of self-care, productivity and leisure, predicated on the interaction of the individual's mental, physical, socio-cultural and spiritual performance" (CAOT, 1991, p. 140).

Occupational Therapy (OT)

Occupational therapy is "the art and science that utilizes the analysis and application of activities specifically relation to occupational performance in the areas of self-care, productivity and leisure. Through assessment, interpretation, and intervention, occupational therapists address problems impeding functional or adaptive behaviour in persons whose occupational performance is impaired by illness or injury, emotional disorder, developmental disorder, social disadvantage, or the aging process. The purpose is to prevent disability and to promote, maintain or restore occupational performance, health and spiritual well-being" (CAOT, 1994, p.81).

Occupational Therapist

An occupational therapist is a member of the occupational therapy profession who, in this province, must belong to the College of Occupational Therapists of Ontario.

Participants

Participants refers to those people, other than the researcher, who participated directly in this research. In particular, it refers to the three group members and the occupational therapist leader of the CLP group.

Patient Education

Patient education is "planned combinations of learning activities designed to help people who have experience with illness make changes in their behaviour conducive to good health" (Goodwin-Johansson, 1988, p. 10).

Productivity

Prductivity refers to "those activities or tasks which are done to enable the person to provide support to the self, family and society through the production of goods and services" (CAOT, 1994, p.82).

Psychoeducation

Psychoeducation is the general label for a model or approach to client education aimed at objectives that relate to mental health/illness. There is no agreed upon definition of the term but a structured group format which utilizes didactic and experiential methods is characteristic of most psychoeducation.

Self Care

"Those activities or tasks which are done routinely to maintain the person's health and well-being in their environment" (CAOT, 1994, p.82).

Therapist

Therapist refers in this study to an occupational therapist, in particular, the leader of the CLP group.

Therapeutic Relationship

"The relationship between occupational therapist and client, which is based on a belief in the uniqueness [sic] worth of each person" (CAOT, 1994, p.83).

Appendix B

Mental Health Clinic Policy Manual

COMMUNITY LIVING PLANNING GROUP

TIME: Wednesday, 1300 - 1500 hours

PLACE: Mental Health Clinic

GROUP SIZE: Maximum 10 members

GROUP FACILITATORS: Two

POPULATION SERVED

Stable, low functioning outpatients in need of support or assistance in setting weekly goals relating to community living.

GROUP REQUIREMENTS

1. Willing to set goals.
2. Motivated to attend group every week.
3. Identified problems structuring time.

GROUP FORMAT

Each client writes their weekly schedules (initially and every 4th week). Each client in turn presents their schedule verbally and gives their impression of how the week felt, including an inventory of what was good. Other members respond; i.e. consider time allotments, give support, help define interests.

Each client sets a goal for the week and analyzes the effect of the previous week's goal.

Discussion of general problems encountered also occurs.

CLP DESCRIPTION, continued

GOALS

1. Clients will take responsibility for, and make decisions concerning what goes on in their lives.
2. Clients will choose a variety and balance of activities.
3. Clients will recognize the need and opportunities for human contact.
4. Clients will demonstrate planning in time segments and recognize individual activities as part of larger goals.

REPORTING

1. Weekly notes will be written in the group book.
2. Progress Notes will be placed in the clinical section of client's casebook a minimum of every three months.
3. Verbal reports will be provided through the group leaders at case conference.

(copied from the Mental Health Clinic 1992 Policy Manual)

APPENDIX C

INFORMATION FOR THE THERAPIST

STUDY TITLE: Occupational Therapist and Client Experiences of an Educational Group.

RESEARCHER: Shirley Jones, Dip(OT), BHSc(OT)
Graduate Student, Master of Education Program,
Brock University

I am conducting a research study to explore the experiences of a group with educational aims from the perspectives of the occupational therapist (co-)leader and the clients involved. Information from this study may help us better understand how to facilitate learning in our clients and how to improve consistency with a client-centred philosophy of practice.

If you are interested in participating in the study, we will determine together which group and members are most suitable. Once I obtain consent from all group members, I will request your signed consent. Then we may arrange times convenient to you for data collection. Data collection will involve an initial interview with you, my observation of at least one group therapy session, and two subsequent interviews with you. I would also like to review relevant documents (e.g. group protocol or your documentation related to the group).

My observations of the group and document review are intended to capture (<u>not</u> evaluate) the details of the group. These will primarily serve to provide a context for information gathered through interviews. During my observation, I will be taking notes but will endeavour to be as unobtrusive as possible so that your regular session will not be disrupted. It is my aim to understand your perspectives of this group, so the interviews will be the most important part of the data collection. All three will be audio-taped and are anticipated to be at most, 60-90 minutes in length. The interviews, which will be more of a conversation, will be unstructured so that we may talk about aspects of the group that are important to you. Similar interviews will also be conducted with several of the group members. I will return the transcripts from our

INFORMATION FOR THE THERAPIST, continued

conversations for you to review for accuracy and any additional comments.

I will also be requesting feedback from you and all of the clients interviewed once the data is collected and analysis is underway. This feedback will be essential in confirming that I have indeed accurately described your experience. We can negotiate the process and timing of doing this.

I will keep all research data in confidence. All "raw" data will be kept in a locked storage area. Tapes will be transcribed by a professional typist who has signed an oath of confidentiality.

Names and identifying information will be disguised upon transcription. Following completion of the study, all data containing identifying information will be destroyed. The study will fulfil part of the requirements for my degree, but may also be used in future research, publication, or presentation.

Your participation in this study is voluntary so you may withdraw from the study at any point. This will not in any way affect your performance record or conditions of employment.

If you have any questions now or at any time during or following the study, you may contact me at (705)647-6815.

Thank you for your consideration.

Sincerely,

Shirley Jones.

APPENDIX D

INFORMATION FOR GROUP MEMBERS

STUDY TITLE: Occupational Therapist and Client Experiences of an Educational Group.

RESEARCHER: Shirley Jones, Dip(OT), BHSc(OT)
Graduate Student, Master of Education Program,
Brock University

I am doing a study of a group (co-)lead by an occupational therapist. Information from this study may help to improve the way therapists lead these types of groups.

I may be looking at the **Community Living Planning Group** that you take part in. If you and the other group members agree, I will sit in to watch and take notes on one or more group sessions. I will be trying to understand what it is like to be a part of this group. I will <u>not</u> be looking at any one person or judging what is going on in the group. I only want to learn about the group.

I will also be talking with the occupational therapist and a few of the group members. I will discuss this part of the study more with these people. I may also look at any notes the occupational therapist writes about the group.

All information that I gather will be kept confidential. No names or details that could identify you will be included.

Your participation in this study is voluntary. If you do agree to allow me to watch your group session(s), you may change your mind at any time. This will not affect your therapy or treatment in any way. If you wish, I will provide you with a summary of the study's results once I am finished.

If you have any questions about this study, you may contact me at (705)647-6815. Thank you for your consideration.

Sincerely,

Shirley Jones.

APPENDIX E

INFORMATION FOR KEY INFORMANTS

STUDY TITLE: Occupational Therapist and Client Experiences of an Educational Group.

RESEARCHER: Shirley Jones, Dip(OT), BHSc(OT)
Graduate Student, Master of Education Program,
Brock University

As you are aware, I may be doing a study on the Community Living Planning Group. I hope to learn what it is like to be involved in this kind of group. The best way I have of doing this is by talking with group members and the group's leader.

If you are willing to talk with me about what the Community Living Planning group is like for you, I will need to set up 3 sessions with you: one before I sit in to watch the group on Wednesday July 6, and two more after. Each session will be at a time and place that is best for you. They will take about one hour and will be tape recorded. Someone has been hired to type out these tapes. This person has agreed to keep all information confidential.

Our talks or conversations will be very informal. I hope to learn from you 3 things in particular:

a) how you came to be a member of this group;
b) what it is like for you to be in this group; and
c) how important the group is for you.

During each session, we will talk about things related to the group that you wish to discuss. You will decide what you want to talk about and will not be pressured to talk if you feel uncomfortable. You may end our talk at any time or withdraw from the study if you wish.

Because I want to be sure that I have understood the things you will share with me, I would like your feedback following our talks. I would like you to check that the typed copies of our conversations are correct. You can add more comments at this point if you wish. I would also like you to review my findings from the study.

INFORMATION FOR KEY INFORMANTS, continued

All information from our conversations will be kept confidential. Your name and any information that may identify you will be changed when the tapes are typed up. The tapes will be kept in locked storage. When the study is finished, they will be destroyed. Your participation will not affect your therapy or treatment in any way.

If you have any questions about the study at this or any time, you may contact me at (705)647-6815. Thank you for your consideration.

Sincerely,

Shirley Jones.

APPENDIX F

SCHEDULE FOR STUDY PARTICIPANTS

STUDY TITLE: Occupational Therapist and Client Experiences of an Educational Group.

RESEARCHER: Shirley Jones [mailing address]

[phone]

1st Conversation — Planned for week of June 27 — Scheduled Date:_____ Time:_____ Place:_____

2nd Conversation — Planned for week of: July 4 — Scheduled Date:_____ Time:_____ Place:_____

Transcripts — I will mail typed copies of our first two conversations to you the week of July 11. This is so that you can make changes or add comments.

3rd Conversation — Planned for week of: July 18 — Scheduled Date:_____ Time:_____ Place:_____

Transcripts — I will mail a typed copy of our 3rd conversation to you the week of August 1. You can share you comments with me by phone or mail.

Analysis Feedback — I will contact you late September or early October to get your opinion on the study results. We can decide at that time how it is best to do this.

APPENDIX G

CONSENT FORM

(for group members and key informants)

STUDY TITLE: Occupational Therapist and Client Experiences of an Educational Group.

RESEARCHER: Shirley Jones, Dip(OT), BHSc(OT)
Graduate Student, Master of Education Program, Brock University

ADVISOR: Dr. Patricia Cranton
(905)688-5550, ext.3340

I, _____, agree to participate in this research study on a group (co-)lead by an occupational therapist. I have received a letter of information about the study. The nature of the study and the expectations of my involvement in it have been explained to me. Questions have been answered to my satisfaction. I understand that I can withdraw my consent at any time without penalty.

_____ _____
Date Signature

_____ _____
Date Researcher Signature

APPENDIX H

Aims for Conversations with Key Participants

(as communicated by reseracher to participants)

I hope to learn from you:

Conversation #1 - How you came to be a member/leader of the CLP group.

Conversation #2 - What it is like for you to be a part of the CLP group.

Conversation #3 - How important the CLP group is for you.

APPENDIX I

Sample Cover Letter - 1st Transcript Review

Monday July 25, 1994

Hi [name]:

Well this is a week overdue - my typing is slow, but improving. This package is a copy of the transcripts typed from the tape recordings of our first two conversations.

There are several things I would like you to keep in mind as you look them over. It's probably best to write these things in as you read through. Feel free to "scribble up" the pages as much as you need to.

1. **Learning and insights.** As you read, you may find that you learn some things about yourself or group. You can write these down.

2. **Important points.** As you will see, we covered a lot in our talks. Please mark the points that stand out for you as those that are most important.

3. **Accuracy.** I know you will find typing errors, but more importantly, please mark any mistakes that change the meaning of what you have said. You can also change things that don't come across the way you meant them to.

4. **Gaps.** There were parts of everyone's tapes that were impossible to hear. These areas are marked with question marks and a number, like this [??135]. I know a lot of time has passed, but if you can recall what was said, please fill it in.

5. **Clarity.** You may be able to think of ways to make what you have shared with me clearer, for instance, adding an example to illustrate something you were talking about.

6. **Anything else.** Any questions or comments or further thoughts that come to mind as you read - please write them down.

A little warning before you start reading our transcripts over - for many people (including me!) it can feel strange at first to read your own words. If it really bothers you, don't hesitate to give me a call.

Cover letter - 1st Transcript Review, continued

When we get together for our third conversation, please bring these transcripts and we can go over them. At that time, I would also like to learn from you how significant or important the Community Living Planning Group is for you.

Thanks [name]] for your time and effort. I will call you within a few days to answer any questions you may have about these transcripts and to set up a time to talk again (perhaps [date]?).

I look forward to our next meeting. Until then...

[signature]

collect [phone]

APPENDIX J

Sample Cover Letter - 2nd Transcript Review

August 10, 1994

Dear [name]:

As promised, here's your copy of the transcript from our last conversation. I find it a little easier every time I go through this process; I hope you will too.

I know you've been through it before, but as a reminder, here's some of the things that I hope you'll make note of:

1. **Learning and insights.** As you read, you may find that you learn some things about yourself or group. You can write these down.

2. **Important points.** As you will see, we covered a lot in our talks. Please mark the points that stand out for you as those that are most important.

3. **Accuracy.** I know you will find typing errors, but more importantly, please mark any mistakes that change the meaning of what you have said. You can also change things that don't come across the way you meant them to.

4. **Gaps.** There were parts of everyone's tapes that were impossible to hear. These areas are marked with question marks and a number, like this [??135]. I know a lot of time has passed, but if you can recall what was said, please fill it in.

5. **Clarity.** You may be able to think of ways to make what you have shared with me clearer, for instance, adding an example to illustrate something you were talking about.

6. **Anything else.** Any questions or comments or further thoughts that come to mind as you read - please write them down.

I'll give you a call around August 20th. Once again, thanks [name], I really look forward to your comments.

[signature]

APPENDIX K

Analysis Coding Scheme

EXPLANATORY NOTES

1. This coding scheme has been organized according to the following topic areas:

    a) Group Leader
    b) Group Member
    c) Getting "Help"
    d) CLP- The Group Session Experience
    e) What group is like
    f) What group could/should be like
    g) What people are like in group
    h) Group's effects/influences on members
    i) Contextual or peripheral information
    j) Global Themes
    k) Miscellaneous

2. All codes included a suffix indicated by an end bracket symbol (i.e., }) to identify the source of the data as follows:

    } **M** Group member participating in conversation
    L Leader participating in conversation
    OM Other group member
    OL Other group leader
    O Other person (somebody not affiliated with the group)
    R Researcher

    Examples: **RES}M** = Comments or questions about the study posed by the group member participating in the conversational interview.
    L-DES}L = Leader's own descriptive comments about herself.

CODES USED IN ANALYSIS

a) Group Leader:

L-DES	Details illustrative of the leader as a person (e.g., demographics, life situation, personality), but not directly related to leader role in group.

b) Group Member:

MEM-DES	Details illustrative of the group member (e.g., demographics, daily routines, "the kind of person I am" statements).
MEM-FTH	Group member's optimistic attitudes and beliefs indicating faith (i.e., in group, in getting better).
MEM-HPLS	Pessimistic statements indicating hopelessness (e.g., "they can't do nothing for me", "I'm too bad")
MEM-ST-	Group member's "self-thoughts" or statements about self of a negative nature, put downs.
MEM-ST+	Self thoughts of a positive nature.
ILL EXP	Illness experience. Perceptions and examples of what it is like to live with a mental illness.
-CA	Cause of, explanation of origins or exacerbators of the illness or symptoms.
-LO	Loss (related to illness).
-ST	Stigma.
-SU	Suicide.
	Example: ILL EXP-ST}M = description by group member of feeling put down by friends because of involvement at mental health clinic.
PR-CUR-ILL	Current problems, difficulties, complaints of an "internal" nature such as those stemming from the mental illness (e.g., difficulty concentrating) or personality features (e.g., low self esteem)
PR-PA-ILL	Past problems, difficulties, complaints.
PR-CUR-SIT	Current problems, difficulties, complaints of a more external or situational nature (e.g., job loss, financial difficulties).
PR-PA-SIT	Past external problems.

c) Getting "Help":

TG PT — Turning point or key issue(s) or incident(s) that seemed to trigger action(s) that eventually lead to group involvement.

TO CLINIC — Process of getting referred to or becoming involved with the clinic.

TX — Treatment or help (separate from CLP group). These categories are not exclusive (e.g. **TX-SELF}M** and **TX-MEDS}M** may indicate a passage where a participant talks of decreasing her medication on her own)

- **-NEEDS** — What the member "needs" to get better.
- **-SELF** — Self treatment, coping strategies, self prescribed.
- **-INFORM** — Help through informal or non-medical/mental health system sources (e.g., a friend's advice).
- **-AT CL** — At clinic (e.g., counselling, psychiatrist)
- **-OUT** — Outside of clinic.
- **-MEDS** — Medication.
- **-OTH GP** — Other group experience.

Example: **TX-NEEDS}L** = Leader's perception of what a group member needs to be able to function better.

d) CLP - The Group Experience:

GP PRE — Pre-involvement thoughts, reactions, awareness related to CLP group.

EN/EX — CLP entry and exit process.

CLP-OUTSID — "Group" outside of the actual CLP session (e.g., discussions about group with counsellor, meetings with group members)

CLP-TIME — Time as a theme, "air time" in group as a right, a valuable commodity.

e) What group is like:

C-HX	Historical information, development of the CLP group.
-CHANGE	Changes in group composition, format etc. over time.
-DES	Description of current state of group.
-S/F	Information specific to structure and format of group.
-DOC	Documentation related to CLP gorup.
-PHYS	Physical setting of the group.
	Example: **C-DES-S/F}M** = A group member's account of a typical session's format.
CLP-	Negative or unhelpful aspects of CLP group that do not fit the following specific codes.
BEL	Not belonging or fitting.
PRE	Pressure.
LET	Let down or disappointed.
CLP+	Positive or helpful aspects of group including general statements or those that do not fit the following specific codes.
ACC	Acceptance as I am.
ADV	Advice.
BEL	Belonging.
COM	Comfort, feeling at ease.
CON	Confidentiality.
INC	Incentive, motivational, hope-giving, goals as helpful.
LEA	Learning.
LIS	Listening to others.
LOO	Something to look forward to.
NOT	I'm not the only one; there are even people worse than me.
PRE	Pressure.
SUP	Support and encouragement.
TAL	Talk, let off steam, open up, say what I want to say.
TOD	Place to go, something to do.
UND	Understanding from others.
GLS	Goals, hoped for changes.
-P	Past.
-C	Current.
-M	For the group member(s).
-L	For the group leader(s).
ATT-M	Attendance, absences of the member(s).
-L	Of the leader(s).

LENGTH-M	Length of time of member's involvement in the group.
-L	Of leader(s).
VAL-M	Value of or importance of the group to the group member(s).
-L	To the leader(s).

f) What group could/should be like:

IMPR	Ideas for improving the group, the ideal.

g) What people are like in group:

ROLE-M	The role of the group member(s) (i.e., What they should/should not do, responsibilities)
-L	Of the leader(s).
REL-M&M	Relationships between group members.
-M&L	Between member and leader.
-L&L	Between leaders.
-#	"Fractures" or inconsistencies, discord, disagreements etc. between leaders.
L INT	Leader intervention, what leader does or does not do in group, including her thoughts, feelings, rationale.
M PAR	Member participation, what member does/does not do in group.
EARLY	Early experiences in group.
PRE S	What happens (actions, thoughts, feelings) before the session (i.e., in the hours or days before group).
POST S	After the session.

h) Group's effects/influence on members:

CH Changes, improvement, effects attributed to group on the people involved.

-IMM Immediate (i.e., hours or days following group) effects on the person.

-M Changes (longer term) in the group member.

-OM Changes in other group members.

-THT Thoughts, insight.

-BEH Behaviour, actions.

-FLG Feelings.

Example: **CH-IMM-FLG}M** = A group member's account of how her mood has usually lifted by the end of a session.

i) Contextual or Peripheral Information:

CLINIC General description or information about the clinic.

-HX Historical.

CL-O GP Clinic, other groups. Also includes comments by leader about groups she's involved with at the hospital.

HOSP Hospital and Rehabilitation department information.

STAFF-R&R Staff roles and relationships outside of group.

PROF Professional issues.

OT Occupational therapy.

-PHIL Philosophy of practice.

j) Miscellaneous:

EXTRAN/? Information that seems extraneous to the study but may be remotely related (e.g., small talk that could illustrate facet of that person's personality) or sections that feel important or interesting but don't fit in existing codes.

RES Research process, comments/questions about the study.

k) Global Themes:

THEY VS Statements revealing we/me vs they outlook, power, control, ownership issues with no obviously positive or negative connotation (according to researcher's interpretation).

VS- Power imbalance, things done to the speaker, lack of control (according to researcher's perspective, not speaker's).

VS+ Partnership, mutual respect, ownership.

-G Related to group or process of getting there.

-O Anything outside the group context.

FAC/RUL Facts, rules, this is the way it is/has to be type of statements.

FUNCT Any comments about function in terms of labelling group members or the group's level.

APPENDIX L

Sample Cover Letter - Findings Review

October 23, 1994.

Hi [name]:

I hope all is well with you. My study of the Community Living Planning Group is coming along well but my deadlines are fast approaching. I'm at the point of writing up the results. I hope you don't mind that I am sending this package to you without checking first over the phone as I had said that I would. I tried to reach you yesterday but there was no answer.

I would like to share parts of my findings with you and the others that participated in the study. I would REALLY appreciate your comments.

The section that I have enclosed is called "The Participants' Experiences". I took everything that people shared with me over the summer and re-wrote it into this "story" of what it is like to be a part of group. The story has three parts:

1. Coming to Group - The first part covers some of each individual's background, how they got to group, problems and difficulties, how they feel before group, and so on. Some of this is personal, so I have only given each person a copy of their own section.

2. The Group Experience - This part focuses more on the group session itself. Everyone's comments have been mixed together, just as a group session is a mix of everyone's experience. I've removed most names and initials to help maintain confidentiality. Of course, your name is only on your copy.

3. Leaving Group - The final part of the story covers criticisms of the group, what people typically do following group, changes in themselves that they feel are a result of group, benefits from group, and other treatment or therapy they are receiving. Again, everyone only has a copy of their own section.

I took care to take out any parts that might embarrass you or offend others. This might make some parts a little hard to follow. Any sections of somebody else's words that have been left out of your copy are marked like this - [XX].

Cover Letter - Findings Review, continued

If this bracket and X is around your own words, it shows what will be left out of other people's copies. People's names have been replaced like this - NAME. I hope that this is not too confusing.

I know that despite my efforts, you will probably be able to piece together who some of the comments belong to. Please, treat what you read as <u>confidential</u>, just as you treat what people share in group.

I will call you on Saturday October 29th. I hope that this gives you enough time to read it over. There are some things that I would like to discuss at that time:

- How "real" the story feels to you. (I know that group has likely changed since we talked. Try to think back to what it was like at the beginning of the summer);

- Anything that you would like me to add or change;

- Let me know what name you would like me to use for you (your own name or a made up name) in my thesis. I will not be using initials; and

- Anything else that you would like discuss.

I'd be happy to share any of the behind the scenes work that was involved in the research, and if you are interested, I will give you a copy of the completed thesis. It will be done early in the New Year.

Thanks again, and I look forward to talking with you soon.

[signature]

APPENDIX M

Therapeutic Factors of Group Therapy

Installation of Hope

Group therapy can instill hope in members who are demoralized and pessimistic, especially through observing others with similar problems who have profited from therapy.

Universality

Disquieting feelings of uniqueness can be disconfirmed through hearing others share similar concerns, fantasies, and life experiences.

Imparting of Information

Information such as the meaning of symptoms, interpersonal dynamics and basic processes of therapy can be implicitly or explicitly provided to members.

Altruism

Members often feel that they are of no value to others and may be morbidly self-absorbed. In group, they can learn that they can offer help to others.

The Corrective Recapitulation of the Primary Family Group

In the group situation members often re-experience familial conflicts and can work toward resolving them.

Development of Socializing Techniques

All therapy groups either explicitly (social skills training) or implicitly (listening, empathy, responding) help members develop social skills.

Imitative Behaviour

Other members and leaders of groups can act as models upon which members may recognize and experiment with new behaviours.

Catharsis

Group therapy offers opportunities for the open expression and release of affect.

Cohesiveness

Group provides as members with a sense of being accepted and valued by others. Cohesiveness is comparable in group therapy to the therapist-client relationship in individual therapy.

Interpersonal Learning

Some groups offer the opportunity for group members to receive feedback as to their own behaviour and to practice their own abilities in dealing with and relating to other people.

(adapted from Yalom, 1983, 1985)